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MEDICAID BILL PROCESSING SYSTEMS TEST

IMPLEMENTATION DOCUMENTATION

VOLUME I - USER'S MANUAL

Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations

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December 1986

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Health and Human Services
Health Care Financing Administration
Medicaid Bill Processing System Test
Implementation Documentation

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CHAPTER I
INTRODUCTION

OVERVIEW

The Medicaid Bill Processing System Test (BPST) is a comprehensive diagnostic tool for states to use in the management of their Medicaid Management Information System (MMIS) and related manual functions. It can be designed to measure the effectiveness of existing claims processing software to make appropriate and accurate payments or to test system changes and enhancements prior to full implementation. It can also be used to identify weaknesses in policy interpretation and policy application within supporting manual functions.

BPST utilizes structured procedures to design specific claims, with predetermined results, for submission to the claims processing system. It also relies on recipient and provider records specifically created and added only for the testing effort. These test claims are then processed through the full claims processing system as if they were actual provider claims for services to "real" recipients.

This document, consisting of two volumes, provides the documentation to plan and implement a test of a Medicaid claims processing system, analyze the results of the test, and plan improvements of the system based on those results. This chapter provides some background on the development of BPST and describes the objectives, capabilities, and uses of BPST.

BACKGROUND

Physician BPST

BPST was initially developed in 1977 to test claims processing controls over payments for physician services. The test consisted of a focused set of erroneous physician billing conditions with corresponding test claims, test providers, and test recipients.

Under this physician-only format, BPST was implemented in some ten states. The reception in these states was highly favorable, and several continued using BPST well after the initial test.

While the physician-only BPST represented a major step in evaluating the adjudication capability of claims processing systems, it had several weaknesses:

- It was not available for other provider types.
- There were redundant test situations.
- Some of the test situations were not realistic.
- There was no capability to tailor the test to unique state conditions.
- There were no procedures for adding test situations to accommodate changes in the Medicaid program.
- There was a need to provide for better control over the test itself.

Expanded BPST

In 1980, in response to these weaknesses, HCFA commissioned a project to expand BPST to other provider types and to provide additional features. The resulting expanded BPST:

- Included test situations for all major provider types
- Organized the test to ensure completeness and to eliminate redundancy
- Added the capacity to tailor the test to specific circumstances
- Introduced control features
- Provided flexibility to accommodate changes in the Medicaid program

The design project and the pilot test in Florida resulted in a three-volume set of implementation documentation:

- A volume on procedures for:
  - Implementation planning
  - Test data preparation
  - Test claims submission
  - Test control
  - Results analysis
- A volume of reference material:
  - Basic test situations
  - Test provider profiles
  - Test recipient profiles
  - Code conversion tables
- A volume of test claims data corresponding to the basic test situations

Related Developments

Amendments to the Social Security Act required all states, with only a few exceptions, to implement an MMIS. In the development of new and replacement systems, states began to use the basic BPST concepts as the basis for acceptance testing of the new software. Through these projects, a number of enhancements to the BPST concepts were developed to accommodate changes in claims processing technology.

These amendments also required HCFA to perform an annual recertification of approved systems. This annual review is accomplished through the Systems Performance Review (SPR). The SPR evaluation has recently replaced the use of initial certification reviews of MMIS systems.

These and other program-related developments which require system changes have resulted in the need for states to more closely monitor their MMIS systems and the system operators. This, in turn, requires that the states have adequate monitoring tools available.

More recently, regulations have been promulgated requiring that states implement a claims processing assessment system (CPAS). States below certain thresholds were allowed to develop their own claims processing quality control procedures to evaluate the systems. Several states have proposed to base their CPAS on BPST techniques.

BPST Training Project

In 1984, HCFA undertook a training project to familiarize state and regional staff with BPST. A total of five classroom sessions were held to which approximately 90 percent of the states and regional offices sent representatives.

The following year, HCFA sponsored BPST implementation in three states: Montana, Minnesota, and Nebraska. The Montana application involved a newly developed system under a fiscal agent operation. The Minnesota and Nebraska applications tested existing state-operated systems.

Documentation Revision

This document represents a revision of the 1981 BPST implementation documentation. It corrects weaknesses identified through the Florida, Montana, Minnesota, and Nebraska applications. It also incorporates the additional concepts developed during acceptance testing in some eleven states.

OBJECTIVES

The objectives of the Bill Processing System Test are to ensure that:

- The Medicaid claims processing system correctly processes claims and all other types of transactions.
- The system makes accurate and timely payments to providers of medical services.
- The system enforces state and Federal Medicaid policy.
- Processing staff are able to perform manual handling and decision-making functions related to claims processing inputs and outputs.

CAPABILITIES

To achieve these objectives, BPST must be able to provide measurable results in which the state can place a high degree of confidence. To achieve the confidence level needed, BPST contains the following capabilities:

- Comprehensiveness - The test can be developed to cover all types of payments, edits, and controls within a claims processing system.
- Flexibility - Because each state's Medicaid program and claims processing system is unique, BPST is designed to be altered to meet each state's unique environment.
- Economy - BPST does not require major systems development and can be implemented with a relatively small number of staff.
- Simplicity - BPST does not require computer expertise to implement.
- Measurability - BPST results not only identify claims processing problems but also identify the source of the problems. The structure of BPST allows determination as to whether problems are systematic, procedural, or policy-related.

USES

Because of its flexibility, BPST can be used in a wide variety of applications. The following paragraphs describe some of the applications for which BPST has been used or for which it has been suggested for use.

Systems Acceptance Test

BPST has been most widely used as the case component of systems acceptance testing. In its most pure form, the BPST technique is useful for testing the capability of the claims processing system to properly adjudicate medical claims. All of the edits, audits, pricing criteria, and operations reporting can be tested.

Specially designed test plans, using BPST techniques, have been developed to test the update capabilities of the Recipient, Reference, and Provider Subsystems. Techniques have been developed to test the on-line update capabilities.

In general, BPST-related techniques are not useful in testing the reporting subsystems, such as MARS, SURS, EPSDT, and TPL. However, wherever those subsystems rely on a transactional update, BPST techniques can be used. For example, testing the system capabilities for maintenance of the SURS control file can utilize BPST techniques.

Policy Evaluation

Test claims can be prepared to test the degree of enforcement of state and Federal policy by the system. In addition to ensuring accurate input, claims processing edits are designed to enforce policy. Results of BPST testing will determine whether the edits are functioning properly. BPST can also be used to determine the impact of policy changes before they are implemented.

System Evaluation

States with older, poorly documented systems can use BPST to evaluate the need for system upgrade or replacement.

BPST can be used to evaluate the system before and after a change in system operator. By comparing the results of each evaluation, the impact of the change in operator can be determined.

Contract Monitoring

States using fiscal agents can use BPST to evaluate contractor compliance with a variety of contractual terms and conditions, particularly compliance with accuracy of processing requirements.

SPR

The Systems Performance Review (SPR) evaluation is being used by HCFA for both the initial certification of a MMIS and for annual recertification. Self-evaluations of the system through BPST techniques can aid a state in preparing for SPR review.

CPAS

States not subject to the mandatory Claims Processing Assessment System (CPAS) are allowed to develop alternative quality control procedures. Combined with an extraction software package, BPST can meet all the criteria of an alternate CPAS.

For evaluating the six CPAS criteria, BPST is the superior technique for:

- Identifying deficiencies in the claims processing operation
- Providing data to determine appropriate corrective action
- Providing an assessment of the State's claim processing operations or that of its fiscal agent

Supplemented by a claims extraction package, a BPST-based CPAS can measure the cost of the deficiencies and provide for a claim-by-claim review.

In either case, the technique will provide an adequate audit trail.

Change Control

Over time, claims processing systems will be enhanced or changed. BPST can be used to ensure that changes will work properly prior to implementation. It can also be used to ensure that the change did not produce any unanticipated changes in other processing routine.

Using BPST for change control is similar to a systems acceptance test, except that only the change is tested. The test can be used for user acceptance of the change before it is implemented.

IMPLEMENTATION DOCUMENTATION CONTENTS

The information and procedures needed by states to develop and implement a BPST application are organized into two volumes:

- Volume I - User's Manual
- Volume II - BPST Test Package

The previous version of this documentation contained a third volume of test claims. Because of the dynamic nature of the Medicaid program nationally and because of the uniqueness of states' individual programs, a set of predeveloped test claims hindered rather than helped implementation of BPST. To encourage states to develop claims that test their own systems, the set of predeveloped test claims has been eliminated from this version.

The procedures and guidelines for development and implementation of a BPST application are provided in the User's Manual. In addition to the introduction (Chapter I) and overview description of BPST (Chapter II), Volume I provides procedures for:

- Implementation planning (Chapter III)
- Development of test situations (Chapter IV)
- Test data preparation (Chapter V)
- Test claims submission (Chapter VI)
- Test control (Chapter VII)
- Results analysis (Chapter VIII)
- System improvement plan (Chapter IX)

The detailed information needed to prepare test claims and conduct a test for the claims system's capability to enforce Federal regulations is included in Volume II. Presented are:

- Functions and features matrix (Chapter I)
- Data element matrix (Chapter II)
- Standard test situations (Chapter III)

- Test recipients (Chapter IV)
- Test providers (Chapter V)
- Reference schedules (Chapter VI)

CHAPTER II
DESCRIPTION OF BPST

OVERVIEW

BPST is not computer software. It is a set of procedures and related data which evaluate the claims processing software and related manual procedures.

BPST consists of specially created recipient and provider records against which a large number of specifically designed Medicaid claims, with predetermined processing results, are processed. Recipient, provider, and claims transactions are comingled into an operational claims processing system.

Test claims are processed in the same manner as any other Medicaid claims transaction. Each claim is designed to present a situation which could result in:

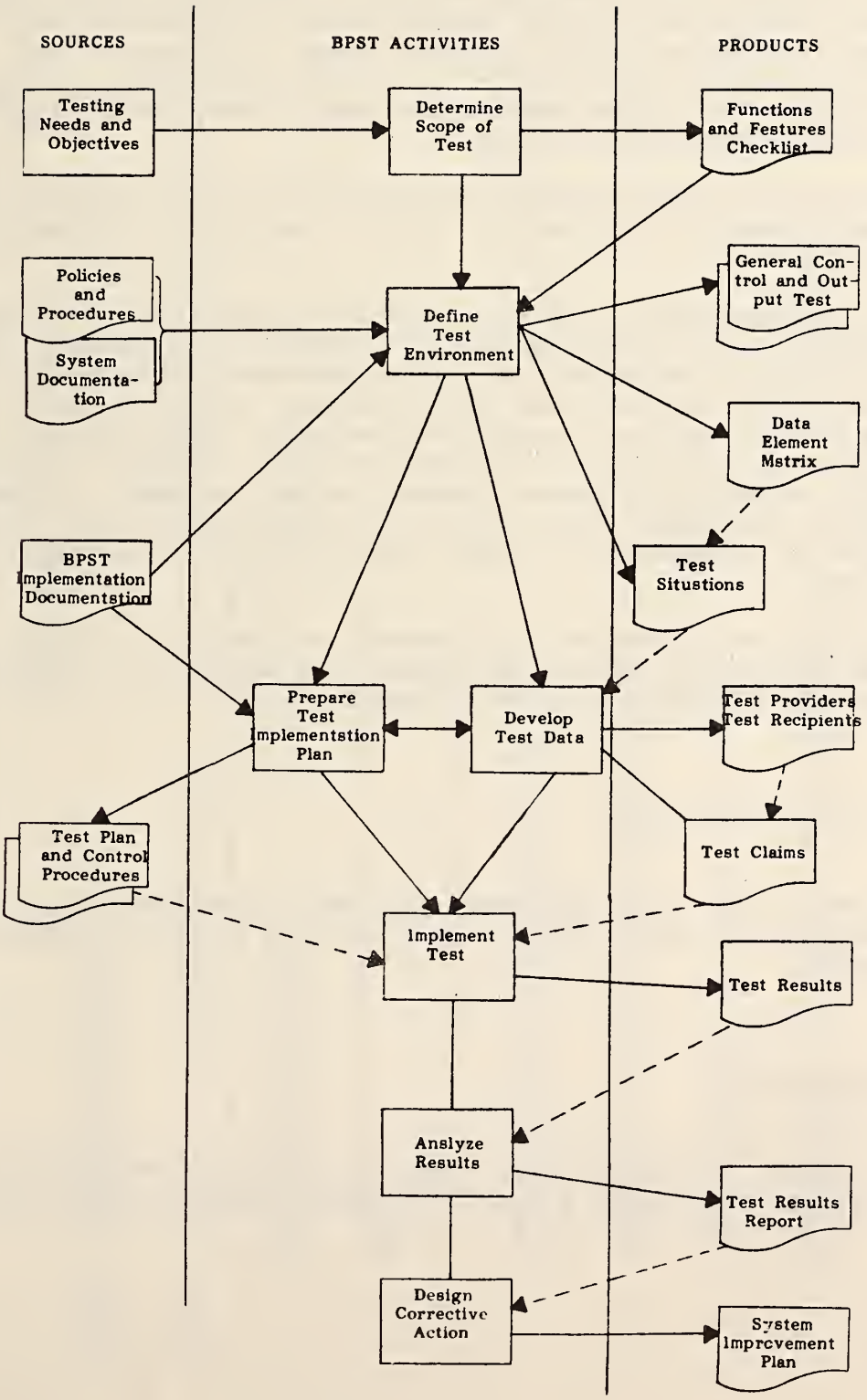
- An erroneous or inappropriate payment
- A payment outside the parameters of state and Federal policy
- A claim for which interim procedures are not applied in a timely, efficient, or correct manner

The processing result for each test claim (payment, denial, rejection) is analyzed and compared to the predetermined result to determine whether the system produced the appropriate outcome based on state and Federal Medicaid policy. Analysis of the total set of outcomes should indicate the strengths and weaknesses of the claims processing system for making appropriate payments.

The purpose of this chapter is to provide a summary description of the elements of the BPST package. An overview of the BPST process is shown graphically in Exhibit II.1. The composite elements are described in summary form in this chapter and described in more detail in subsequent chapters.

EXHIBIT II.1

BPST OVERVIEW



FUNCTIONS AND FEATURES

The starting point of a BPST application is establishing the scope of the test. The scope can vary widely depending on the reason for testing. At one extreme, a comprehensive BPST application can be designed to test and evaluate the entire claims processing system for purposes such as acceptance testing or system evaluation. At the other extreme, the scope may be limited to a single condition for testing a newly developed policy statement or testing a system change.

The scope of the test is defined through the use of the Functions and Features Checklist. An example of this checklist is illustrated in Exhibit II.2.

Each system has certain functions which it must fulfill or features which it must have. These functions and features are listed on the checklist. The middle columns of the checklist are used to determine how the function or feature will be evaluated. Most can be evaluated through the use of the structured data test, the primary BPST technique. Some functions and features cannot be tested on a transactional basis, but must be tested through observation, document review, review checklist, or other judgmental techniques. This is called the general control test. Some functions and features relate to system outputs and can be tested through an output test.

A beginning set of functions and features are provided in Volume II, Chapter I. These are the required functions and features for an MMIS as defined in Part II of the State Medicaid Manual.

STRUCTURED DATA TEST

The core of BPST is the structured data test, or transaction test. The composition of the structured data test is described in the following three subsections.

Test Situations

The core of BPST is the set of test situations. Each test situation is the set of conditions which define a test of the claims processing system. Test

EXHIBIT II.2

SAMPLE FUNCTIONS AND FEATURES CHECKLIST

FUNCTIONS AND FEATURES CHECKLIST

Subsystem: Claims Processing Subsystem

Number	Function and Feature	Structured Data Test	General Control Test	Output Test	Comments
	The Claims Processing Subsystem must accomplish the following objectives:				
A1	Ensure that all input into the subsystem is captured at the earliest possible time and in an accurate manner.	X	X		
A2	Establish control over all transactions during their entire processing cycle.		X		
A3	Verify that all providers submitting input are properly enrolled.	X			
A4	Ensure that all recipients for whom input is submitted were eligible for the type of service at the time the service was rendered.	X			
A5	Ensure that all input submitted to the subsystem is processed completely.	X			
A6	Verify that charges submitted by providers are reasonable and within acceptable limits.	X			
A7	Ensure that reimbursements to providers are rendered promptly and correctly.			X	
A8	Maintain accurate and complete registers and audit trails of all processing.			X	

situations are defined by one or more test claims which present the situation to the system.

An expected outcome is assigned to each situation based on the manner in which the test claims should be processed. Comparison of the actual outcome of processing test claims to the expected outcome provides the basis for evaluating the effectiveness of the system.

The test situations, listed in detail in Volume II, Chapter III, were developed and are organized by claim data element and test type.

The data elements are organized by the Medicaid Management Information System (MMIS) numbering scheme. This approach allows BPST to be organized in the same manner that system controls are established. These controls operate by examining the data provided by provider claims and by supporting subsystems to detect error conditions. The data elements are examined in relation to themselves, in relation to other data elements within the claim, and in relation to data elements in other claims.

The Test Claim Data Element Matrix shown in Volume II, Chapter II, illustrates the claim data elements, ordered in MMIS data element number sequence. The left side of the matrix indicates the type of edit(s) performed on each element, and the right side identifies the applicable provider types. Many data elements, such as recipient ID number, are submitted by all provider types, while some elements, such as prescription number, are related to specific provider type.

The left side of the matrix, "Test Types," indicates the types of edits performed on the data elements by a claims processing system for which tests can be developed. These edits can be classified into three general categories:

- Edits for data element integrity
  - Presence, where required
  - Format
  - Validity (may require interrogation of reference file[s])
- Edits for data interrelationships (compatibilities and/or constraints)
  - Consistency
  - Reasonableness
- Edits for claim interrelationships (compatibilities and/or constraints)

- Benefit limitations
- Duplication
- Conflict

Test Providers

Because the BPST claims are contrived, test providers must be enrolled and available to the system for processing BPST claims. The test providers used should be based on the provider types recognized by the state. The right side of the Test Claim Data Element Matrix is a comprehensive grouping of providers. It indicates which data element tests are applicable to a specific provider type.

The list of test providers provided in Volume II, Chapter V assumes that the state recognizes those provider types. By utilizing the data element matrix, the set of providers can either be expanded or reduced, depending on the needs of the state.

Test Recipients

In addition to test providers, test recipients must be available to the system for processing BPST claims. Volume II, Chapter IV provides a detailed listing of recipients, including:

- Name
- Social Security number
- Sex
- Relation to case head
- Date of birth
- Third-party coverage
- Basis of eligibility

As in the case of providers, this can can be expanded, contracted, or altered to fit the needs of the state.

GENERAL CONTROL TEST

Certain functions and features cannot be evaluated through a transactional based test. They can, however, be evaluated through a variety of judgmental techniques such as:

- Observation
- Document review
- Structured checklist review
- Structured interviews

In these cases, a unique test mechanism must be developed for each function or feature. The test design and results evaluation must be left to the judgment of the reviewer. The format shown in Exhibit II.3 allows for documentation of the specialized test design and for recording results of the analysis.

Examples of functions and features which must be evaluated through the general control test include:

- System control features
- Manual processing features
- On-line inquiry testing
- Adequacy of documentation

OUTPUT TEST

The structured data test is designed to test the system's capability for accurately processing inputs. System outputs are used in the evaluation of structured data test results. Therefore, it is also prudent to evaluate the outputs.

MMIS outputs are of three main types

- On-line or screens
- Files

EXHIBIT II.3

GENERAL CONTROL CHECKLIST

Function or Feature Number	Description	Test Situations	Result	
			OK	Comment

- Reports

Screens are frequently identified as an output medium rather than a type. For purposes of BPST, however, on-line screens will be identified as a type of output.

In the test environment, outputs can be generated and evaluated through the use of the output checklist illustrated in Exhibit II.4

IMPLEMENTATION, CONTROL, AND ANALYSIS

The most important and challenging aspect of testing the system is the structured data test. The remainder of this volume and most of Volume II will be devoted to an explanation of the implementation, control, and results analyses of the structured data test. For this purpose, the terms BPST and structured data test will be used interchangeably.

Applying BPST in any state requires extensive planning, close control, and detailed analysis.

Adequacy of the implementation planning and execution can mean the difference between success and failure of the BPST effort. A test situation, for example, with an expected outcome which is contrary to state policy is an invalid test. Test situations can also be made invalid by errors in claim preparation or claim submission. In this volume, Chapter III provides detailed procedures for implementation planning which, if followed, will ensure success of the test effort. Chapters V and VI provide procedures for data preparation and claims submission to avoid errors that will invalidate the tests.

Once the test is initiated, control procedures should be applied to avoid losing claims and to ensure that the results are properly recorded and adequately tabulated. Test control procedures are presented in Chapter VII.

Analysis and interpretation of the results of BPST claims processing is discussed in Chapter VIII. This analysis forms the basis for evaluation of the system. Upon completion of the evaluation, a systems improvement plan can be developed to delineate and prioritize corrective action. The development of the systems improvement plan is discussed in Chapter IX.

EXHIBIT II.4

OUTPUT CHECKLIST FORM

Reference Number	Name	Screen File Report	Frequency	Media/ Copies	Produced	Format	Balanced	Data Validated	Comments

CHAPTER III
IMPLEMENTATION PLANNING

OVERVIEW

The success of a BPST application is dependent on the extent and quality of planning. The purpose of this chapter is to present suggestions for planning the BPST application which will help avoid the pitfalls that could invalidate the test.

The planning procedures are presented under the following headings:

- Scheduling
- Staffing
- Preliminary Activities
- Test Situation Selection
- Implementation Issues
- Implementation Conference
- Implementation Guide

SCHEDULE

The entire BPST application could be accomplished in approximately 150 elapsed days. These days should be allocated by phase as follows:

- Planning Phase - 30 days or four weeks
- Implementation Phase - 90 days or 13 weeks
- Analysis Phase - 30 days or four weeks

The tasks associated with the Planning Phase are described in this chapter. The tasks and detailed schedule associated with the Implementation and Analysis Phases are included in Chapters VI and VIII, respectively.

The overall project schedule is illustrated by the Gantt chart in Exhibit III.1. This chart shows the suggested timing for the entire project.

STAFFING

There will be at least five specialists needed to plan and implement BPST. These individuals are described in the following paragraphs:

Test Coordinator

This individual will act as project manager and should have knowledge in Medicaid policy, claims processing systems, and information retrieval. He should also have some experience in project management.

The test coordinator should be assigned full-time to the project and would have responsibility for overall project management; preparation of input documents; receipt and control of remittance advices, checks, and ID cards; test control monitoring, and post-test purging of the files.

Eligibility Coordinator

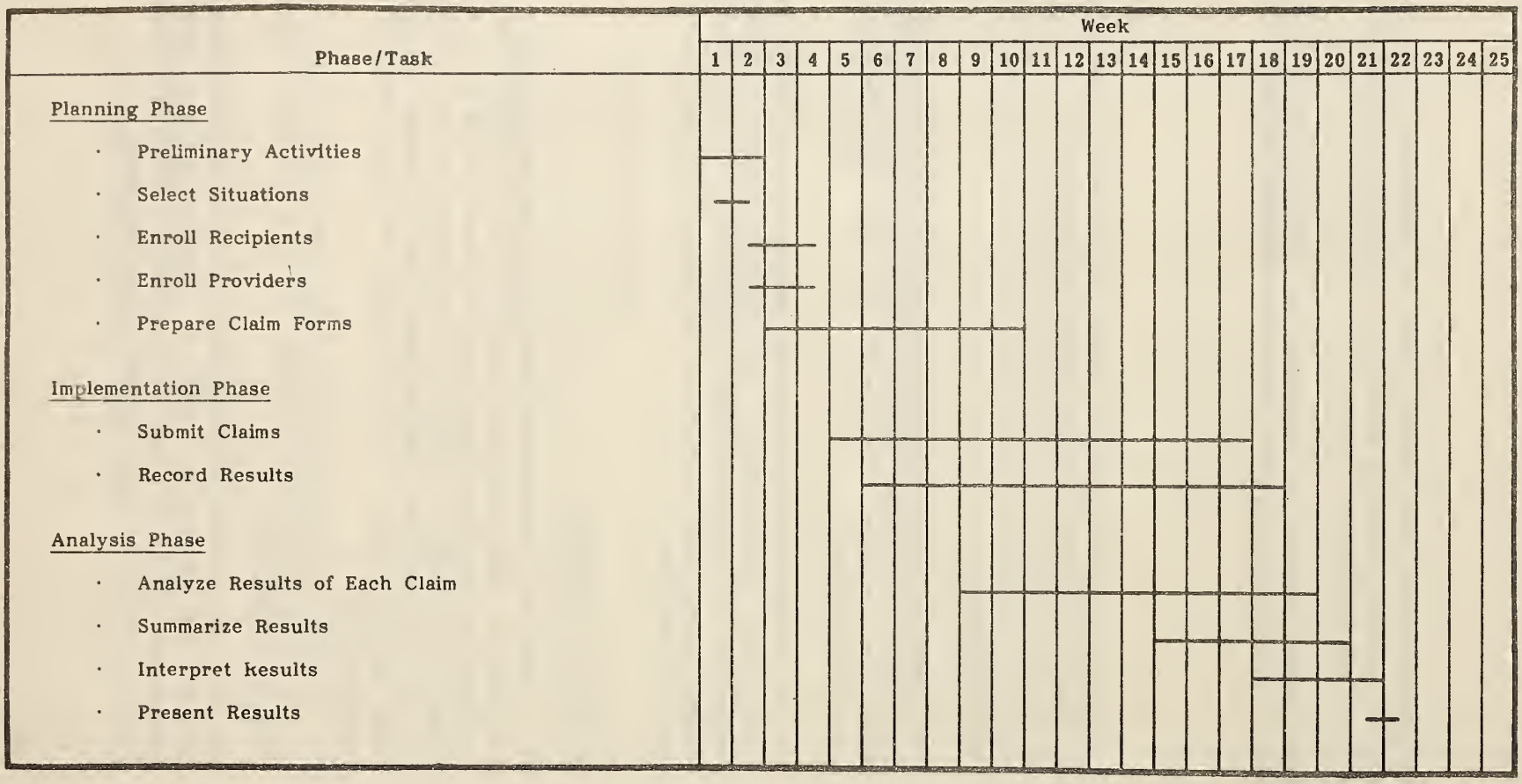
This person should be knowledgeable about the recipient input forms and process. This individual should be able to explain what data elements are mandatory and how the forms should be completed. Usually this person is responsible for adding the test recipients to the file. In one state, this individual was a manager at a county social services office. In other states, this person came from the Medicaid staff.

Provider Coordinator

The provider coordinator should know the provider file maintenance process and should be able to explain provider enrollment procedures. This individual will normally be drawn from either the Provider Relations or the Provider Enrollment staff.

EXHIBIT III.1

SUGGESTED BPST IMPLEMENTATION SCHEDULE


Phase/Task
Week
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
Planning Phase
· Preliminary Activities
· Select Situations
· Enroll Recipients
· Enroll Providers
· Prepare Claim Forms
Implementation Phase
· Submit Claims
· Record Results
Analysis Phase
· Analyze Results of Each Claim
· Summarize Results
· Interpret Results
· Present Results

Claims Processing Coordinator

The claims processing coordinator should have detailed knowledge and experience in the policy and procedures in claims processing. This individual must be able to explain which entries are required on a claim and how to complete a claim properly. Frequently, this person is or has been a claims processing supervisor.

Program Policy Coordinator

The success of a BPST application depends on correctly assessing the expected outcome of a test situation based on state and Federal policy. This person's role will be to assist the test coordinator in the selection of test situations, assignment of expected outcomes, and analysis of results.

Other Resources

The test coordinator should be provided sufficient resources to ensure success of the project. These resources include:

- Program specialists to assist in selection of test situations and analysis of results
- Clerical personnel to assist in the preparation of claims, proofreading, mailing, and receipt of outputs
- Advice from the medical and dental advisors to the Medicaid program

State experience has proven that BPST implementation is an excellent teaching and learning tool for individuals not experienced with the system. However, it is also recognized that the test is most efficiently performed by staff that have a significant understanding of the process.

PRELIMINARY ACTIVITIES

Several preliminary activities must be accomplished before the input documents can be developed. These activities are described in the following paragraphs.

Identification Numbers

State-assigned identification numbers are needed for approximately 167 cases (236 recipients) and 50 providers. Recipient identification numbers should be assigned from a contiguous block of unassigned numbers which have never been used. Both recipients and individual providers have already been assigned Social Security numbers.

Provider Names

The provider names in Volume II, Chapter V should be checked against real providers in the state. If duplicate names occur, the test provider names must be changed.

Post Office Box

Preparations should begin to rent post office boxes in two to three locations to serve as provider and recipient addresses. U.S. Postal Service regulations prohibit delivery of mail to an addressee if it differs from the name of the box renter. The cooperation of the postmaster where the boxes are rented should be solicited.

Eligibility File

Frequently, the eligibility file is used for welfare operations as well as Medicaid. If so, appropriate clearances should be obtained. In the case that grant payments are automatically generated, such payments can be prevented by indicating a no-payment status and/or $0 amount. As a back-up control, the post office box will catch any ID cards that are produced.

Procedure and Drug Codes

Lists of procedure, drug, and diagnosis codes used for the test are provided in Volume II, Chapter VI. HCPCS codes are used for physician, clinic, and outpatient hospital claims. For inpatient hospital claims, the ICD-9-CM procedure codes are used. The American Dental Association (ADA) coding is used on dental claims. For pharmacy claims, the National Drug Codes (NDC) are used. ICD-9-CM diagnosis codes are used on all claims requiring diagnosis codes.

Each list contains a blank column in which the test coordinator can enter the corresponding state code, if different from the code used on the claim. If procedure codes needed for the test are not used by the state (e.g., procedure for cosmetic surgery), appropriate substitutes should be found.

Reimbursement Allowances

While converting procedure codes, schedules of maximum allowances for each provider type will be used in preparing claim forms. Several claims call for "by report" procedures. If those are not by report in the state, appropriate substitutions should be made. The method of reimbursement for institutional providers must be determined. The options for hospitals are usually comprehensive per diem rate or room rate plus ancillary charges. For nursing homes, it could be a daily or monthly rate.

Prior Authorization

Several test situations require prior authorizations. The procedures for obtaining prior authorizations must be established and steps should be taken to obtain authorizations before testing.

Test Materials

The materials for the test should be assembled as soon as possible. As a minimum, the following materials are recommended:

- Provider claim forms
- Recipient enrollment input form
- Provider enrollment input form
- Prior authorization forms
- Sterilization consent forms
- Claim attachments (e.g., operative reports)
- State Plan

- Policy manuals and guidelines
- Provider billing guidelines
- Form instructions for claim forms, recipient input forms, and provider input forms
- Procedure code manual and schedules of maximum allowances
- Diagnosis code manuals
- Sample remittance advices

Note: If claim forms and/or prior authorization forms are controlled through preprinted numbers, forms from a block of contiguous numbers should be used. This will facilitate test control.

TEST SITUATION SELECTION

The most important implementation planning task is the selection of the test situations to be used. The situations and expected outcomes provided in Volume II, Chapter III should be altered or deleted to conform to state policy. Additional situations can be added to test conditions of interest to the state. Deletion of situations should not be made if the error condition cannot be detected by the claims processing system. However, the expected outcome should be changed to reflect the probable processing disposition.

The following resources should be used during the selection process:

- State Plan
- State policy guidelines
- Provider billing guidelines
- Advice of program specialists
- Advice of the medical advisor
- Claims processing system design

In some cases, the provider type assigned to a test situation is not recognized by the state. Appropriate changes should then be made. In addition, the state may elect to emphasize a new or problem provider type. Many test situations can be altered to use a different provider type. The Test Claim Data Element Matrix in Chapter II of Volume II indicates the applicable claim types. Any provider type which submits the claim type(s) applicable to the data element and test type can be used for the test.

IMPLEMENTATION ISSUES

Several issues must be addressed and resolved during the planning phase. These issues are discussed in the following paragraphs:

Recipient Enrollment

The process for establishing recipients on the eligibility file used by the claims processing system should be examined to determine at which point the recipient should be entered. Enrollment of BPST recipients should be accomplished so that all data elements to be used are recorded on the eligibility file. Procedures for handling retroactive eligibility and four-month continuing eligibility should be identified.

Provider Enrollment

Normally, BPST providers can be enrolled in the same manner as real providers. The enrollment process for the state should be reviewed, however, to ensure that no problems will be created.

An extremely important issue is to determine how to prevent generation of IRS Form 1099s for BPST providers. This can be accomplished by a credit balance on the provider file, a program trap in the 1099 generator program, or by purging the provider file prior to the time for 1099 issuance.

Awareness of the Test

It is necessary to conduct the test without the knowledge of the individuals who process the claims. There are advantages to involving the manager of the claims operations so that questions raised by claims processing personnel can be answered consistently.

Also, claims managers frequently contribute ideas to improve the test realism.

County or District Office Involvement

To the extent necessary, the county or state department district offices should be made aware of the test so that material they receive relating to the test can be directed to the test coordinator. For example, if ID cards are generated to be distributed at the local level, the cards for BPST recipients should be directed to the test coordinator. Local offices may have to be involved in enrollment of BPST recipients.

Fiscal Agent Involvement

The manager of the fiscal agent operations for the State should be involved in the implementation planning process. Often, it is the fiscal agent-developed system which is being tested by BPST, and involvement of their management is as important as involvement of state department management. Some of the fiscal agent staff may have to be involved in this test. For example, if providers are enrolled by the fiscal agent, the provider enrollment manager should be involved in the implementation planning. Finally, a representative of the fiscal agent should be involved in the evaluation of test results to aid in determining the cause of unexpected outcomes.

Some states have preferred to make BPST blind to the fiscal agent management. This can be done at the State's option. However, the test will eventually become apparent to the fiscal agent and the State should be prepared to respond to the inevitable questions. This option also eliminates the testing assistance which can be provided by the fiscal agent management.

Checks

If checks are generated for BPST providers, the test coordinator must void these checks upon receipt and maintain careful control. If the state prefers not to generate checks, the provider accounts can be established with credit balances, or BPST provider claims can be removed from the adjudicated claims tape prior to its use in the check-write process. Procedures for control of checks are provided in Chapter VIII.

ID Cards

In many states, ID cards are automatically generated monthly from the recipient file. These documents should be voided upon receipt by the test coordinator and controlled in the same manner as are the checks. The ID card, however, should not be immediately voided if it has a "sticky label" which is to be used in a test situation.

Telephone Contact

If provider contact is primarily by telephone, a telephone answering service can be used to handle inquiries. Alternatively, the provider relations unit can participate in the test and can be used to handle inquiries.

The list of issues and suggested solutions is not exhaustive but points out the need for careful exploration of all relevant issues prior to proceeding with the test.

IMPLEMENTATION CONFERENCE

One method for making the selection of test situations and resolving implementation issues is to conduct an implementation conference. A sample agenda for such a conference is shown in Exhibit III.2.

The initial session should be conducted by the test coordinator and include as attendees:

- Personnel involved in the project
- State Medicaid management
- Fiscal agent management
- Other department officials involved in the project
- Representatives of other state departments who have interest in the project, such as the State Treasurer's office or State Auditor's office

The purpose of the initial session is to introduce the project, explain it, and solicit management support for the effort.

EXHIBIT III.2

SAMPLE AGENDA
BPST IMPLEMENTATION CONFERENCE

Afternoon - First Day

Introduction of Project Participants
Introduction to BPST
Introduction of Purpose of Project
Question and Answer Session

Morning - Second Day

Review of Issues
Recipient Enrollment Activities
Provider Enrollment Activities

Afternoon - Second Day

Selection of Test Situations for:
- Physician Services
- Hospital Services
- Laboratory and X-Ray Services
- Family Planning Services

Morning - Third Day

Selection of Test Situations for:
- Nursing Home Care - SNF
- Nursing Home Care - ICF
- Nursing Home Care - ICF-MR
- Home Health Care
- Clinic Services
- Podiatry Services

Afternoon - Third Day

Selection of Test Situations for:
- Pharmacies
- Audiological Services
- Visual Services
- Dental Services

Morning - Fourth Day

Selection of Test Situations for:
- Transportation Services
- EPSDT Screening

Afternoon - Fourth Day

Resolution of Remaining Issues
Discussion of Implementation Schedule

The balance of the conference sessions are devoted to resolving implementation issues and selecting test situations. The attendees at these sessions should be state specialists in the areas being discussed.

IMPLEMENTATION GUIDE

To prepare for the implementation conference, the test coordinator should obtain as much of the information as possible suggested by the guide presented in the Appendix. This can be done through knowledge of the system, discussion with appropriate specialists, or researching state manuals and guidelines. Remaining questions or issues can be resolved at the implementation conference.

CHAPTER IV
DEVELOPMENT OF TEST SITUATIONS

OVERVIEW

The core of BPST is the set of test situations. The purpose of this chapter is to explain the process of test situation development in terms of:

- How test situations are constructed
- Translating policy to test situations
- Translating system documentation to test situations

CONSTRUCTION OF TEST SITUATIONS

The starting point of all testing, BPST or otherwise, is the test objective. From the test objective, the tester can identify the appropriate provider types, data elements, and test types to be constructed. Once the test objective has been clearly defined, the preparation of the test situation is a relatively simple task. This progression is described in the following paragraphs.

Testing Objective

The testing objective is a statement of what is to be accomplished. It can be very general. For example, an objective of an MMIS acceptance test is:

> "...to ensure that the MMIS system correctly processes claims and all other types of transactions."

To meet this objective, all of the test situations listed in Volume II will be translated into test claims.

The objective of a one-time or annual quality control review project is different in nature than the full system test. For ongoing reviews and for system testing, the objectives should be more specific. An example of a specific objective is:

> "...to determine whether the system will make payments to a physician who has been suspended or terminated."

A specific objective such as this will translate into one or only a few test situations.

For testing system changes, the statements of objectives can range from very specific (e.g., "to determine if edit X is functioning properly") to very general (e.g., "to determine if hospital claims are processed correctly"). Again, the number of test situations and test transactions increases as the specificity of the statement of the objectives decreases.

Testing Mechanism

When a testing objective has been stated, specific transactions by which the test is accomplished must be determined. At this point, the data element matrix becomes a part of the test documentation.

By reviewing the Data Element Matrix in Volume II, the tester can identify the data element under which the test should be conducted. For example, if the objective is to determine whether the system will make payments to suspended or terminated providers, the appropriate data element is the provider exception indicator (data element 225). This is the appropriate data element because when a provider is under suspension, that indicator is used by the claims processing routines to determine whether to suspend the claim for manual review. However, some systems carry a provider enrollment status code on the provider file to accomplish this purpose. Therefore, all data elements should be investigated to see which is most applicable to the test.

Once the proper data element is selected, the appropriate test type must be determined. The test types are shown on the left side of the matrix. In the provider exception indicator example, the determination of suspension or termination is carried on the provider file. Thus, the appropriate test type is "H" or Conflict. The definitions of test type are provided in Exhibit IV.1.

EXHIBIT IV.1

TEST TYPE DEFINITIONS

Test Type	Code	Meaning
Presence	A	Data element must be present, if required.
Format	B	Data element has specific format (alphabetic or numeric).
Validity	C	Data element must be one of a set of predefined values.
Consistency	D	Data element must be logically consistent with one or more other data elements within the same input transaction.
Reasonableness	E	Data element which must fall within a range of reasonable values (e.g., high/low dollar values).
Benefit Limit	F	Data element(s) must conform to a defined service limitation policy.
Duplication	G	Data element(s) which is a key item must not be a duplicate.
Conflict	H	Data element(s) in a transaction must be logically consistent with current file data within the subsystem.

Each data element is input into the system through one or more input sources. For the claims processing test, these input sources are claims or claim-like documents (prior authorizations, adjustments, etc.). For each test (data element and test type), the input source for that test must be selected. If the data element applies to all claim types, any one may be selected. Alternatively, the test can be repeated for all claim types. The claim types are identified on the right side of the data element matrix.

The tester now has all elements of a test situation: objective, data element, claim type, and type of test. At this point, the test situation can be constructed.

Test Situation Identification

A test situation number is used to link each claim to a situation, providing excellent control over the test. The situation numbering scheme is composed of the data element, the test type, a sequence number, and an input source. Exhibit IV.2 displays the format of the test claim situation numbering scheme.

Using the provider exception indicator example, if the objective of the test is to test whether claims will be paid if the provider is suspended, then the test situation number would be:

0225-H01-A

The number "0225" is used because that is the provider exception indicator data element number; "H" shows it is a conflict test; "01" shows it is the first or only conflict test for that data element; and "A" reflects that the test situation is presented on a HCFA-1500 claim form.

The test situation statement should always be constructed to clearly identify the test:

- "Provider number is missing."
- "Provider is ineligible on date of service."
- "Provider is under suspension on date of service."

EXHIBIT IV.2

TEST CLAIM SITUATION NUMBERING SCHEME

Format 999-X99-X

9999 Data element number using the MMIS numbering system shown in the Volume II Data Element Matrix.

X99 * "X" is the type of edit being performed for the data element.

"99" is the sequential situation number for a given type of edit with a data element number.

X ** Input source (claim type)

* Type of Edit	** Input Source (Claim Type)
A - Presence	A - HCFA-1500
B - Format	B - HCFA-1450 (UB82)-Inpatient
C - Validity	C - HCFA-1450 (UB82)-Outpatient
D - Consistency	D - LTC Turnaround Document (Nursing Home)
E - Reasonableness	E - Pharmacy
F - Benefit Limitation	F - Transportation
G - Duplication	G - Dental
H - Conflict	H - EPSDT Screening Invoice
	I - Prior Authorization
	J - Home Health
	K - Adjustment

Note: EMC billings and tape crossovers will use the same claim type indicators as paper claims.

TRANSLATING POLICY TO TEST SITUATIONS

Nearly every rule or policy in state Medicaid programs which relates to provider billing or payment can be translated into a test situation. For example, the Administrative Rules for one state include the following policy statement:

> "No clinic, group, institution, corporation, or other association which is a provider of services shall submit claims for payment to the Division for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program, except for those services or supplies provided prior to the suspension or termination."

Compliance of the MMIS with this policy statement can be tested through test situations such as:

> 0225-H01-A Performing provider is under suspension on date of service.
>
> 0225-H02-A Performing provider was terminated prior to date of service.

The reason for stating that "nearly every" rule can be translated into a test situation is that some rules cannot be enforced by the claims processing system. Compliance of the system with these rules cannot, therefore, be tested. An example of such a rule is:

> "Suspected child abuse will be reported at the time of the submission of a request for payment from the Division by a health care provider."

TRANSLATING SYSTEM DOCUMENTATION TO TEST SITUATION

Evaluations of claims system operation or changes to the claims system can be performed using test situations. For example, the detail system design of an MMIS includes the following processing description:

> "All claims which have third-party coverage indicated on the TPL Case Master File, which do not have third-party money reported on them, and which have a billed amount of less than $50, are paid."

Adherence to this design specification can be tested through test situations such as:

0329-D01-B Billed amount under $50 and no TPL payment indicated; recipient is TPL eligible.

CHAPTER V
TEST DATA PREPARATION

OVERVIEW

The preliminary groundwork, described in the previous chapter, should be completed before the input documents are prepared. Particularly important is the selection and refinement of test situations.

The purpose of this chapter is to provide principles for translating test situations to test data and to describe the procedures for:

- Enrolling test recipients
- Enrolling test providers
- Preparing test claims

TRANSLATING TEST SITUATIONS TO TEST DATA

When a claims processing system processes a transaction, it is designed to organize and compare the transaction data to data on hand and make a decision on disposition of the transaction. All decisions are predetermined, but the data presented can represent a very large combination of conditions. The purpose of BPST is to determine whether the system will make a correct decision with a given set of conditions. To be effective, test data must adhere to several principles:

- The test must be under control of the tester.
- The condition being tested must be isolated from other conditions.
- The combination of data must present the exact condition to be tested.

These principles are described in the following paragraphs.

Test Control

Test control procedures will be discussed in detail in Chapter VII. For those procedures to be effective, however, the test transactions must contain traceable control data.

The primary control feature is the test control number. This control number began with the selection of a data element number. Added to that, as shown in the previous chapter, was the test type, corresponding sequence number to identify each test situation, and input source. In preparing test claims or other test transactions, this control number can be further expanded to provide unique identification of each transaction, down to claim line number. The format for the test claim control number is illustrated in Exhibit IV.2

Alternatives to use of the test control number are to use either the provider number or recipient ID to identify test claims. However, these are not generally unique to each test claim.

Test Isolation

As much as possible, tests of a claims processing system should be conducted under conditions of "Semper Peribus" or "All Else Remaining Equal." Some errors can mask other errors and prevent the test from determining whether the edit or process being tested is functioning properly. For example, a claim with a performing provider which suspends for "Provider Not on File" will not test the condition of "Provider Under Suspension."

To achieve this condition, each test transaction should contain only one error condition. All other data in the transaction should be valid and consistent with the error data as if it were not in error. Thus, an entirely valid transaction should be created with only the data needed to create the error changed to the desired error condition.

One example of error masking is on date testing. If the test situation was "billing date is prior to admission date" on an inpatient claim, but the admission date was in error (e.g., April 31), the test is invalid. In this case, the admission date must be valid.

Combination of Data

This principle, which is very similar to the principle of test isolation, states that the combination of data must present the exact condition to be tested. For field tests, such as "Procedure code is missing," adherence to this principle is relatively simple. In this case, the procedure code is simply omitted from the test claim.

In other cases, the combination of data is necessarily complex. To test whether the system can detect an invalid diagnosis/procedure code combination, for example, the selected procedure code must be in conflict with the diagnosis code and the system must be designed to detect procedure/diagnosis mismatches.

RECIPIENT ENROLLMENT

A list of test recipients and their characteristics is provided in Volume II, Chapter IV. Using this list and the information and input documents obtained previously, the following tasks should be performed:

- Eliminate any recipients that no longer have test situations. Add recipients for newly added test situations for which there are no recipients, or distribute new test situations to existing recipients.

- The year of recipient birth is provided in the profiles as years prior to the test. Compute the recipient's birthdate with respect to the start of the test.

- If not done previously, assign a state identification number to each recipient. For control purposes, these numbers should be from a contiguous block of unused numbers.

- Using the data now assembled, fill out a state eligibility file data input form for each test recipient or case. Be sure to properly employ any codes which prevent automatic monthly payments to recipients on cash assistance programs. All addresses should be listed as the post office box referred to earlier. When the form is complete, remove or reproduce a copy and keep it for reference.

- Submit the original input form to the file update process. Note that in one case a recipient is to have a prior period of eligibility. In another case, a recipient is to have a change in ID number. In these situations, it may be necessary to enter forms in two consecutive file update cycles, depending on the state's procedures.

- Obtain any transaction turnaround documents which may be generated during the eligibility file update process and proof them carefully, paying special attention to ensure the accuracy of names, ID numbers, and addresses, including zip codes. Initiate corrections as needed.

- Determine whether test recipients will be included in Medicaid Quality Control (MQC) samples. Take steps to remove them from any samples selected or coordinate with the Quality Control unit to eliminate selected recipients from field reviews.

PROVIDER ENROLLMENT

A provider list and detailed provider profiles are included in Volume II, Chapter V. Using this information, as well as the information gathered during implementation planning, the following tasks should be performed:

- Eliminate providers which no longer have test situations. Add providers for newly added test situations as necessary.

- Compute provider enrollment dates for all providers. Nearly all enrollment periods can be assigned to coincide with the test start and end dates. The exceptions are noted in the provider profiles.

- If not done previously, assign a state identification number for each provider.

- If license number is a mandatory item on either the provider file or the claim form, assign a number to each provider requiring one. In some states, a dummy number, such as "9999," will be sufficient. In other states, unused out-of-state license numbers may have to be obtained from the appropriate licensing boards.

- Using the data now assembled, fill out a state provider file data input form for each test provider. All addresses should be listed as the post office box referred to earlier. It may also be necessary to include a special telephone number. When the form is complete, remove or reproduce a copy and keep it for reference. Submit the original form to the file update process.

- Obtain any transaction turnaround documents which may be generated during the provider file update process and proof them carefully, paying special attention to ensure the accuracy of names, ID numbers, specialties, telephone numbers (if applicable), and addresses, including zip codes. Initiate corrections as needed.

- Prepare entries on any other provider lists or files which may be referenced during claims processing (e.g., provider telephone or address directories).

TEST CLAIM PREPARATION

During the implementation planning procedures described in Chapter III, the test situations to be used should have been selected and refined. This selection and refinement should be based on state policy and claims processing system capabilities, as well as the needs of the state.

Based on this selection and refinement, the appropriate type of claim form should be used to prepare test claims for each situation selected. For situations not selected, the reason should be noted in the applicability section, and the claim form should not be developed. For situations added, new claim forms should be prepared. Each provider claim form, prepared under the procedures described here, presents the test claim to the system.

The identification numbers assigned by the state for each recipient and each provider should be annotated on the appropriate claim form. Prior authorization numbers needed for the claim and the billing date, based on the test schedule, should also be annotated.

Test Claims

To prepare test claims, the following data is needed:

- The statement of objectives (why is the test being conducted?)
- The test situation with expected outcome
- Billing instructions for the claim form and provider type
- Appropriate provider number(s)
- An appropriate recipient number
- Appropriate service codes (procedure, diagnosis, drug, tooth number, etc.) with pricing data

The claim should be prepared completely and accurately as if it were an actual claim for which the provider wanted payment. The billing intructions should be used for this purpose and should be followed judiciously. (Note that if there are errors in the billing instructions, they should be detected if the claims are completed in accordance with the instructions.) When the claim is complete, the data fields in which the errors are to be created are changed to the error condition.

The test control number should be entered into the patient account number field on the following claim forms:

- HCFA-1500
- HCFA-1450 (UB-82)
- Dental
- Individual Adjustment

Use of this number of the claim form will facilitate control, particularly in those states in which the provider's patient account number is included on the remittance advice.

On the Drug claim forms, the test control number can be entered into the prescription number field. For forms which do not have a patient account number, another appropriate field or alternative method should be used.

For claims requiring attachments, the appropriate attachments, such as a sterilization consent form, should be completed and attached. For claims requiring operative reports, a sheet stating "This constitutes an operative report" can be used.

For claims requiring prior authorization, a PA request should be completed, and the PA file should be updated. The PA number should be entered on the claim form.

Dates in the structured test data are provided in relation to the start of the test. For example, recipient birthdates are illustrated as "12/12/-35", which means that the recipient was born on December 12, 35 years prior to the start of the test.

All claims and attachments should be reviewed, proofread, and sent to the mailroom for batching. The claims should be proofread by a second individual to ensure that no inadvertent errors were created.

Copies of the claim form, attachments, and screen prints of the PA file update should be retained for the test workpapers. As each claim is completed, prepare a Claim Detail Control Sheet for that claim. These control sheets are described in Chapter VII.

Coordination of Test Data

The coordination of test data across subsystems is important to ensure compliance with the principles of test isolation and combination of data. Not only is it necessary for the data on the test transaction (claim) to be valid and consistent, but related data in the support files (Provider, Recipient, and Reference) also has to be consistent with the test conditions.

For example, if the test situation is to determine if "the level of care code billed is invalid for the level of care code on recipient file," the test conditions require:

- A valid level of care code (test isolation)
- A nursing home provider eligible for that level of care (test isolation and combination of data)
- A recipient in that nursing home but at a different, valid level of care (combination of data)

- A valid claim for that provider, recipient, and level of care (test isolation and combination of data)

If the test situation were for "multiple surgeries on claim and another claim in history," the test condition requires:

- A valid provider eligible to perform surgery (test isolation)
- A valid recipient (combination of data)
- Multiple, valid, consistent surgery codes (test isolation, combination of data)
- Valid consistent diagnosis codes (test isolation, combination of data)
- Related claim in history (combination of data)

Claim Preparation Examples

Detailed examples of claim preparation are provided in Appendix B. Examples for both a HCFA-1500 claim form and a HCFA 1450 (UB-82) claim form are included.

CHAPTER VI
TEST CLAIMS SUBMISSION

OVERVIEW

This chapter describes a set of procedures for controlling the submission of claims and a schedule for submission of the claims.

It is not necessary that all claims be prepared before the start of the test. To maintain the schedule, however, claims for the first four to six cycles should be ready by the start of the test.

SUBMISSION PROCEDURES

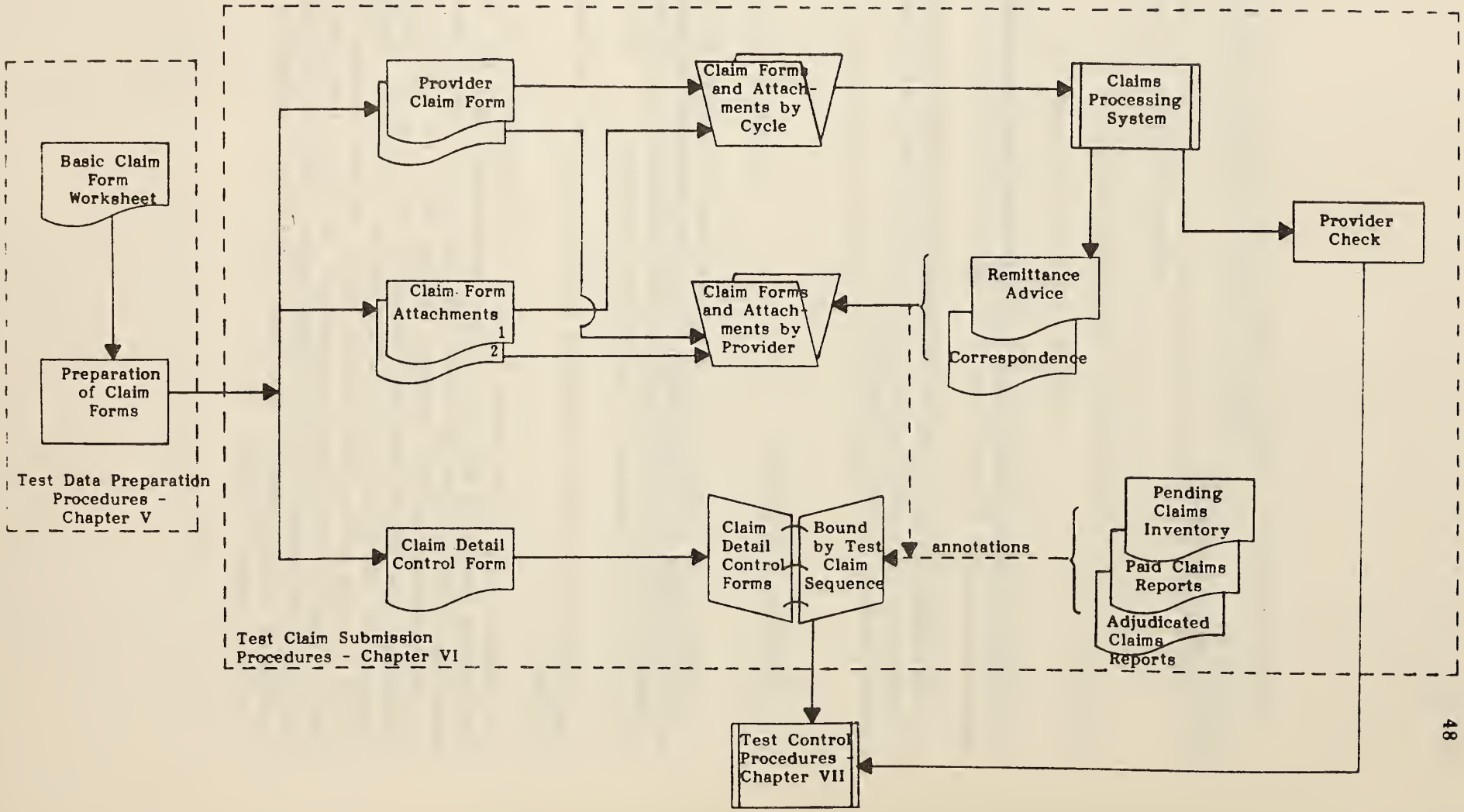
In addition to the overall test control described in Chapter VII, the test coordinator needs to exercise control over the submission of claims. The necessary procedures for control of claims submission are illustrated in Exhibit VI.1 and are discussed in the following paragraphs.

The provider claim forms should be carefully prepared, as described in Chapter V.

The original copy of the claim forms and the original copy of required attachments should be filed in a claims submission tickler file. This file should consist of a folder for each of the cycles that is clearly labeled with the cycle number and the scheduled mailing date. The folders should be periodically checked to make sure that all claims are in the file, including attachments, and other needed documentation is included. Missing items should be noted on the folder jacket to remind the test coordinator that the item is required prior to claims submission. As missing items are received, they should be crossed off of the folder jacket. Examples of items needed subsequent to completion of the claim include "sticky labels" or coupons from the recipient ID card.

EXHIBIT VI.1

TEST CLAIM SUBMISSION PROCEDURES


Basic Claim Form Worksheet
Preparation of Claim Forms
Test Data Preparation Procedures - Chapter V
Provider Claim Form
Claim Form Attachments 1 2
Claim Detail Control Form
Claim Forms and Attachments by Cycle
Claim Forms and Attachments by Provider
Claim Detail Control Forms
Bound by Test Claim Sequence
Claims Processing System
Remittance Advice
Correspondence
annotations
Pending Claims Inventory
Paid Claims Reports
Adjudicated Claims Reports
Provider Check
Test Claim Submission Procedures - Chapter VI
Test Control Procedures - Chapter VII

After all documentation is complete, the claims should be mailed for input to the claims processing system.

The provider copy of the claim and its attachments should be filed in a provider file. This file should consist of a folder for each test provider. Included in this file should be:

- Provider copy of the provider enrollment input form
- Provider copy of test claims submitted
- Provider copy of claim attachments
- Remittance advices
- Correspondence

The provider file provides a repository for test provider-related documentation, as well as cross-reference material for provider activity.

The claim detail control sheet is prepared at the same time the claim is prepared. This sheet, one for each test claim, should be filed in a three-ring binder for easy reference. The documents in the binder should be in test claim number sequence. This file should be updated from remittance advices, pended claims inventory reports, paid claims listings, and adjudicated claims listings. The file of claim detail control sheets serves as input to the test control procedures described in Chapter VII.

SUBMISSION SCHEDULE

The claims should be assigned to cycles on the following basis:

- To emulate normal provider billing cycles (e.g., nursing home and pharmacy bill monthly at the beginning of the month)
- To ensure longitudinal integrity of recipients and providers (e.g., claims should not be submitted for a suspended provider unless intended; claims should not be submitted for a dead recipient unless intended)
- To maintain integrity of the test situations (e.g., for multiple test situations, the claims should be submitted in the proper order)

- To distribute the workload for claims submission as evenly as possible

CHAPTER VII
TEST CONTROL

OVERVIEW

The purpose of this chapter is to provide procedures and tools the test coordinator can use to track the test claims through the claims processing system and determine the processing results. The tools described in this chapter also allow summarization of the results of the test so that the analysis, described in Chapter VIII, can be performed. Automation potential of these procedures is briefly discussed. Procedures for maintaining an audit trail of the test are also described.

DETAIL CLAIM CONTROL

The primary tool for test control is the Claim Detail Control Sheet, shown as Exhibit VII.1. This form permits the test coordinator to record on each claim all data needed to meet each of the following control functions:

- Claim identification
- Test control
- Check control
- Disposition analysis

The data for each of these functions is recorded in a separate section on the form. These functions are described in the following paragraphs.

Claim Identification

The data in this section is used to identify the claim itself and provide for cross-reference to provider and recipient lists and the list of test situations. This should be recorded as the test claims are prepared.

EXHIBIT VII.1

CLAIM DETAIL CONTROL SHEET

Claim Situation No. _____ Transaction Control No. _____

Recipient ID No. _____ Provider ID No. _____

Recipient Name _____ Provider Name _____

Test Control Data

Cycle No. _____ Provider Type _____ Current Status _____

Date Mailed _____ Date Received _____ No. of Days _____

Check Control Data

Check No. _____ Amount _____

Check Date _____ Date Voided _____

Remittance Advice Date _____ Date Prepared _____

Disposition Analysis

Expected Disposition _____ Actual Disposition _____

Amount Billed _____ Amount Paid _____ Difference _____

Comments:

The transaction control number data element is the system-assigned control number used by the state's claims processing system. This identifier will aid the test coordinator in tracking the claim through the system. The transaction control number is usually stamped on the source document and can be obtained by daily review of entered claims by the test coordinator.

Test Control Data

The purpose of this section is to record data used for controlling and monitoring claims submission and flow. The data should be recorded as the test claims are mailed and as information becomes available.

The "Current Status" data element is for optional use by the test coordinator. If the coordinator periodically queries the system, the status of a claim at that point can be determined and recorded.

The data in this section will be the basis for the test control worksheet discussed later in this chapter.

Check Control Data

The check control section is provided for those states which elect to issue checks. For states which elect to enroll "no-pay" providers or to remove claims before check-write, this section will not be needed.

The Claim Detail Control Sheet is maintained on a claim-by-claim basis. Most claims processing systems, on the other hand, will produce a single check for each provider, and the check and remittance advice data for each provider will be recorded on all of the applicable Claim Detail Control Sheets. Thus, the Check Control Log discussed later should also be used.

Disposition Analysis

The purpose of this section is to aid in the evaluation of the effectiveness of the claims processing system. At this level the claims for which the actual disposition and the expected disposition are different are analyzed for appropriateness of outcome. The data from this section is used to develop the Disposition Analysis Matrix.

SUMMARY CONTROL MATRICES

The data collected and posted to the Claim Detail Control Sheet should be used to develop summary matrices for analysis purposes. The following paragraphs describe the minimum number of matrices that will be needed. Others can be added to meet the needs of a particular state.

Test Control Worksheet (Exhibit VII.2)

This worksheet provides the bridge between the Claim Detail Control Sheet and the other summary matrices. The primary purpose of this worksheet is to organize the test situations by provider type and by test type. A separate worksheet should be prepared for each provider type, and the test claims should be organized by test type.

The columnar data is entered directly from the Claim Detail Control Sheet for each claim. The test coordinator should ensure that every claim is entered on the Test Control Worksheet. At this point, summaries will start being made; if any claims are omitted, the summaries will be in error.

Check Control Log (Exhibit VII.3)

The Check Control Log is optional to the extent that the production of checks is optional during an application of BPST. If check production is elected, the Check Control Log is vital to prevent loss of state resources during the test.

The form of the log will depend on the check-handling process of the state. The example shown contains the minimum information for any state. The log can be maintained in provider order or check number order.

Disposition Analysis Matrix (Exhibit VII.4)

The Disposition Analysis Matrix provides a mechanism to analyze the processing outcomes of BPST. The format is designed to provide disposition analysis for each test situation. For ease of analysis, however, the disposition of each claim should be shown on the matrix.

EXHIBIT VII.2

TEST CONTROL WORKSHEET

Provider Type _____

Test Claim Number	Number of Days in Mail	No. of Days To Suspend or Adjudicate	Number of Days in Suspense	Number of Days to Return	No. of Days for Check Processing	Total Days	Disposition	Amount Billed	Amount Paid
Totals No. of Claims									

EXHIBIT VII.3

CHECK CONTROL LOG

Provider			Check			Check Register			Date Received	Date Voided	Remittance Advice No.
ID No.	Name	Address	No.	Date	Amount	No.	Date	Ref.			

EXHIBIT VII.4

DISPOSITION ANALYSIS MATRIX

Situation No.	Claim Situations	Expected Disposition	Actual Disposition	Code	Amount Billed	Amount Paid	Conclusion

The "Code" column allows the test coordinator to indicate for each test situation or claim. This format makes counting easier for summary purposes. The suggested analysis codes are:

√	=	Processed as expected
X	=	Actual disposition varies from expected disposition
-	=	Situation was not tested or not tested properly
O	=	Claims have not been processed to final disposition
ⓧ	=	Actual disposition varies from expected but is in accordance with state policy

The test coordinator should utilize other state experts to assist in the analysis and formulation of the conclusion. For each test situation in which the expected and actual disposition differ, the conclusion should state the most likely cause. An example of a completed disposition analysis matrix is shown in Chapter VIII.

THROUGHPUT ANALYSIS

Federal standards for timeliness of claims processing requires that 90 percent of clean claims be adjudicated in 30 days and 99 percent of clean claims be adjudicated in 90 days. Some states have even more stringent requirements. The purpose of throughput analysis is to determine if a timeliness problem exists.

Because BPST claims are contrived and because very few BPST claims are clean claims, this analysis cannot be used as an absolute measurement of the timeliness of claims processing. However, it can be used as a problem identification tool.

Throughput analysis involves the measurement of the average processing time of BPST claims through the system. The Throughput Analysis Matrix (Exhibit VII.5) can be used to compute the average processing time.

The data for completing the matrix can be obtained from a printout of the history record of the BPST claim. Relevant data elements for each claim are:

EXHIBIT VII.5

THROUGHPUT ANALYSIS MATRIX

Claim Type	Number of Days to Suspend or Adjudicate			Number of Days in Suspended Status			Number of Days to Return			Number of Days for Check Processing			Total Days in System		
	Claims	Days	Avg.	Claims	Days	Avg.	Claims	Days	Avg.	Claims	Days	Avg.	Claims	Days	Avg.
Totals															

- Date received (e.g., julian date in claim TCN)
- Date suspended (if applicable)
- Date adjudicated (date approved for payment)
- Date paid (e.g., check date or RA date)

The data for each claim should be summarized by claim type and entered into the Throughput Analysis Matrix. A review of the matrix will identify any potential timeliness problems by claim type.

AUTOMATION OF TEST CONTROL

The test control mechanism suggested in this chapter has been designed to be used manually by the test coordinator. However, the design will also permit automation.

Many of the items on the Claim Detail Control Sheet can be regarded as data elements. Rather than filling blanks on paper, the values of these data elements can be input to an automated system. Programs can then be used to compute fields, such as "number of days," on the control sheet. These programs can also be designed to print the summary matrix formats shown. A variety of commercial electronic spreadsheet software packages can accommodate the matrices that are used.

Automation will not, however, eliminate the judgemental aspect of the test. Automation will be useful only to permit the test coordinator more time to exercise judgement.

AUDIT TRAIL

The purpose of an audit trail for a BPST application is to enable an outside reviewer to follow the test process to determine if the conclusions reached in the results analysis were justified. The outside reviewers might include:

- The State Auditor's Office
- HCFA Bureau of Quality Control

- HHS Inspector General, Office of Audit
- State management analysis

The audit trail is established through the BPST application workpapers. The best method for maintaining the workpapers is in a three-ring binder with divider tabs. For documents too large for the binder, a reduction copier can bring them down to size. For documents too large for the binder and too voluminous to copy (e.g., computer printouts), supplementary binders can be used but should be carefully cross-referenced to the primary workpapers.

Documents contained in the workpapers should include:

- Functions and features matrix
- Test situation lists
- Test control worksheet
- Throughput analysis matrix
- Check control log
- Disposition analysis matrix
- Copies of all input documents prepared for the test
- Copies of all screen prints of on-line transactions
- All reports related to test transactions
- Other related computer output, including:
  - Medicaid ID cards
  - Provider checks
  - Remittance advices
  - Suspense worksheets

The workpapers should be organized into a rational, easy-to-follow manner. One suggested organization scheme would be:

- Section A
  - Statement of objectives
  - Related narrative
  - Schedule
  - Report on results

- Section B
  - Data element matrix
  - Test situations
- Section C
  - Test control worksheet
  - Throughput analysis matrix
  - Disposition analysis matrix
- Section D
  - Non-claim transaction input documents
  - Screen prints with error messages
  - Related reports
  - Results analysis
- Section E
  - Test claims
  - Detail claim control sheets
  - Check control log
- Section F
  - Remittance advices
  - Suspense resolution worksheets
  - Related reports on claims transactions

CHAPTER VIII
RESULTS ANALYSIS

OVERVIEW

The previous chapter provided procedures for test control, results recording, and results summarization. When the test results are recorded and summarized, they must still be analyzed and interpreted.

This chapter provides procedures for analysis of the results, a basis for interpretation of results, and a format for presentation of the results. Plans for system improvement are discussed in Chapter IX.

ANALYSIS OF RESULTS

The Disposition Analysis Matrix introduced in Chapter VII is the primary tool for results analysis. The matrix is used to identify test situations in which the actual disposition differs from the expected disposition. Investigation of the variances is the crux of results analysis; therefore, the variances should be identified and scrutinized whenever they occur.

There can be many reasons for the variance, such as incorrect identification of the expected disposition. In this case, the expected disposition should be changed so the variance no longer exists. Reasons that will prompt further investigation include:

- Claim incorrectly processed by claims processing system
- Absence of system edits to identify erroneous payment situation
- Inaccurate reduction of amount billed

A sample completed Disposition Analysis Matrix is provided in Exhibit VIII.1.

EXHIBIT VIII.1

DISPOSITION ANALYSIS MATRIX

Situation No.	Claim Situations	Expected Disposition	Actual Disposition	Code	Amount Billed	Amount Paid	Conclusion
306-C	Diagnosis code submitted is not valid.	Deny	Pend	O	498.00		Letter requesting information sent, provider did not respond - Will be denied after appropriate interval
306-D1	Diagnosis is incompatible with recipient's sex (e.g., diagnosis is pregnancy, sex is male).	Deny; verify against written description	Deny	√	10.00	-0-	
306-D2	Diagnosis is incompatible with recipient's age (e.g., diagnosis is inter-menstrual bleeding, age of recipient is 5 years).	Deny; verify against written description	Pay	(X)	15.00	15.00	Recipient inadvertently put on file as male - No test. Diagnosis/sex conflict noted but claim paid. Diagnosis/age conflict not detected - Policy issue
306-D3	Diagnosis indicates accident; no third-party liability.	Pay/ investigate	Pay and follow-up	√	50.00	50.00	
306-D4	An accident-related procedure and diagnosis are listed but claim form indicates that injury was not an accident.	Pay/ investigate	Pay	√	1,063.00	849.84	Should not be considered third-party situation - System keys on accident-related block.
311-A	Admission date is missing.	Return or deny	Pay	√	846.00	846.00	Pended for admit date - Manually resolved based on information contained on claim - Good use of claims resolution staff.
311-C	Admission date is not valid date (see standard validity date checks).	Return or deny	Pay	(X)	676.00	676.00	Date entry clerk changed date - Should have pended for claims resolution
311-D1	Admission date is outside recipient's period of eligibility.	Deny	Pay	(X)	701.00	701.00	System relied on district worker's approval of claim - Policy issue of where to place controls
311-D2	Admission date is outside provider's enrollment period.	Deny	Pay	-	240.00	240.00	Unable to decertify provider at mid-month - No test

INTERPRETATION OF RESULTS

After analyzing the results, the next critical step is interpreting those results. The question to be answered is "Does the analysis of results lead to the conclusion that a system weakness exists?" This concept is discussed in the following paragraphs.

The interpretation of the results analysis of test claims is a subjective exercise that requires an integrative approach. Explanation of system results is best provided by individuals with a keen understanding of the system and of the various factors that influence outcome.

Interpretation of the results can lead to the identification of weakness. If the outcome for all or a majority of the tests varies from the expected disposition, a systematic problem may be indicated, and further investigation may be warranted. If, on the other hand, only one or two tests vary from expected dispositions, a systematic problem may not be indicated.

PRESENTATION OF RESULTS

When the analysis and interpretation of results are completed, the test coordinator must present the results to those officials responsible for effecting change. Although this presentation cannot be standardized, an approach can be taken which will make the presentation more understandable.

The approach is based on answering five questions for each system or policy weakness identified:

- What is?
- What should be?
- Why isn't it?
- So what?
- What can be done?

Using a third-party liability testing example, the five questions might be answered in the following manner:

- What is? - The answer to this question presents the identified condition or weakness. For example, "the system is paying claims without investigation even though there were indications that third-party liability might exist."

- What should be? - Relevant criteria based on state policy or Federal regulation should be used to answer this question. In the absence of "hard" criteria, this question can also be answered through opinions of state experts.

- Why isn't it? - This is presentation of the cause of the variation. For example, "the claims processing system does not contain edits which will suspend claims for investigation of potential third-party liability."

- So what? - Answering this question requires presentation of the effect of the weakness. It could be quantified from the test, as "BPST claims in the amount of $_____ were paid without investigation even though they contained evidence of third-party liability." Or this question could be related to other matters, as "this weakness could lead to decertification of the MMIS resulting in a loss of $_____ of FFP."

- What can be done? - This answer provides a recommendation for action. It should also discuss the cost of the recommended action and comparison of that cost to the savings that could be realized. For example, "edits should be programmed for identification of third-party liability situations. This will result in a cost of $_____ for programming and an estimated $_____ per year for investigation."

FURTHER INVESTIGATION OF RESULTS

The cost/benefit analysis of recommendations cannot always be satisfactorily accomplished by quantification of BPST results. Further investigation is often warranted to identify the actual extent of the condition.

One method is to examine a sample of paid claims. Software is available which will allow extraction of samples from a history file. A year of claims history can be examined through a relatively small sample. The examination for a particular occurrence will indicate its frequency among actual paid claims. Quantifications of the sample can be used to strengthen the presentation of results.

CHAPTER IX

SYSTEM IMPROVEMENT PLAN

CHAPTER IX
SYSTEM IMPROVEMENT PLAN

OVERVIEW

After completion of the test and presentation of results, the test coordinator should prepare a System Improvement Plan. A system improvement plan is the translation of identifed errors and deficiencies into a workable corrective action strategy. A scheme for system improvement is best conveyed and implemented when in a written format. Drafting an improvement document is a discipline that encourages an analytical approach to the BPST findings and to the subsequent corrective actions.

The System Improvement Plan should be organized so that the following items are addressed:

- Explanation of BPST
- Identification of the issues
- Alternative corrective measures
- Corrective actions selected
- Monitoring of problem resolution

EXPLANATION OF BPST

It is important for the System Improvement Plan to contain a clearly written statement that summarizes the BPST process and the results obtained. This allows readers not familiar with the test to understand the basis of approach for system improvement. The narrative is also helpful for individuals who understand the principles of BPST when references are made to applications and outcomes for each new test. The narrative should contain a synopsis of the significant events in the planning and implementation of BPST. The products of the results analysis should also be included. From review of the narrative statement, the reader should

develop an understanding of what has preceded the conclusions and corrective actions.

IDENTIFICATION OF ISSUES

Problems found in BPST testing can be attributed to one or more of the following factors:

- Policy deficiencies
- Inadequate staff training
- System deficiencies

Policy Deficiencies

Payment policies can sometimes be vague or not address completely all types of claims found within Medicaid programs. Therefore, processing may be subject to variation from the program's intent. Restating the policies in language that clearly defines the situation and the accompanying procedures can provide the foundation for improvement.

Policies for certain conditions may not exist due to changes in the program or simple oversight. In this case, new policies should be developed to address the lack of direction in current policies.

Inadequate Staff Training

Errors in manual procedures or in the human intervention activities in claims processing can be found in BPST. If policies exist that define the situations in which the error occurred and the policies are not followed, then staff training is in order.

System Deficiencies

Deficiencies of the automated claims processing system can be in one of two forms:

- Deficiencies of omission
- Deficiencies of commission

The deficiencies of omission are elements lacking in the system, such as appropriate edits and audits that enforce the program's policies. The deficiencies of commission involve the incorrect processing of claims due to improper system design. An example of improper system design would be payment of a pharmacy claim without including the dispensing fee.

ALTERNATIVE CORRECTIVE MEASURES

If multiple corrective measures are available to resolve identified problems, each alternative should be thoroughly discussed in the System Improvement Plan. The advantages and disadvantages are to be listed for each alternative. The alternatives discussed should be presented in an objective manner. The favored alternative is named and examined in the next section.

CORRECTIVE ACTIONS SELECTED

The response to each problem identified in the BPST should be prominently stated. Exhibit IX.1 shows how the Disposition Matrix from Chapter VII can be amended with an extra column that indicates the corrective action taken. This arrangement allows easy association between the problem and the solution.

For identified problems that allowed multiple solutions, detailed justifications should be provided for the selected choice. The justification can include items such as a cost-benefit analysis or an analysis of decisive factors.

EXHIBIT IX.1

DISPOSITION AND CORRECTIVE ACTION MATRIX

Situation No.	Claim Situations	Expected Disposition	Actual Disposition	Code	Amount Billed	Amount Paid	Conclusion/Deficiency	Corrective Action

MONITORING OF PROBLEM RESOLUTION

Once a corrective action approach has been selected, the management of the corrective action must begin. Exhibit IX.2 displays a matrix that facilitates control of corrective action activities. The matrix associates a party with primary responsibility for completion of each activity. Estimated person-hours, start and completion dates, and costs are included for concurrent and post-completion review of the activity. The corrective actions can be indexed so that actions are cross-referenced to the problem situations listed in the Disposition/Correct Action Matrix.

EXHIBIT IX.2

SYSTEM IMPROVEMENT ACTIVITY MATRIX

Activity Description	Primary Responsibility	Project Hours	Start Date	Completion Date	Estimated Cost

APPENDIX
BPST IMPLEMENTATION GUIDE

PURPOSE

These guidelines are designed to assist the BPST test coordinator to understand the elements of the Medicaid claims processing system. With the information developed through the use of this guide, the test coordinator can develop new test situations, modify or eliminate existing test situations, or otherwise tailor the test to meet the needs of the state. The guide is organized into the following sections:

- Understanding the Medicaid Program
- Understanding the Claims Processing System
- Developing the Set of Test Situations
- Establishing Test Recipients
- Establishing Test Providers
- Calculating Payment
- Scheduling the Test
- Post-Test Procedures

UNDERSTANDING THE MEDICAID PROGRAM

1. Using the State Plan and other sources, identify all services covered by the Medicaid program. List each service covered.

2. Using the State Plan, State laws and regulations, and other sources, identify any limitations, copayments, prior authorizations, certification requirements, or other effects on the amount and duration of coverage for each of the services listed in Step 1.

3. Identify all provider types recognized by the State. For each provider type, identify the services listed in Step 1 that each provider type is permitted to provide.

4. Using the State Plan and other sources, identify all eligible types covered under the Medicaid program. List each eligible type and identify any limitations on service coverage for each eligible type.

5. Using provider billing guides, determine the claim form (claim type) to be used for each provider and each service covered. Identify claim attachments that are to be used in various circumstances. Obtain sterilization consent forms, examples of operative reports, etc.

6. For services requiring prior authorizations, as identified in Step 2, determine how prior authorizations are to be obtained. Identify the forms to be used, the lead time required, and any special signatures or certifications required.

7. Using policy guidelines and manuals, determine the roles of the provider and the state in seeking third-party payments. Is the provider required to bill and exhaust all third-party coverage prior to submitting a claim to Medicaid? Does the state pay for services and then try to collect third-party payments ("pay and chase")? Are potential accident liability investigations conducted? If so, are they conducted before or after payment to the provider?

8. Determine the process for crossing over Medicare claims. Do providers bill Medicaid directly or does the Medicare carrier/intermediary forward a claim, or both? Investigate the feasibility of eliciting the Medicaid carrier/intermediary's cooperation in preparing cross-over claims and Medicare EOMBs.

9. Review the lists and other documentation prepared under this section with state Medicaid program specialists to ensure accuracy and completeness.

UNDERSTANDING THE CLAIMS PROCESSING SYSTEM

1. Prepare or obtain a flow diagram of the claims processing system. The diagram should be a summary data flow diagram rather than a detailed program logic diagram. It should illustrate the flow of a claim from the provider through prescreening, claims processing, check-write, and into history files and remittance advice

preparation. If different claim types are processed differently, a flow diagram for each claim type should be prepared.

2. Obtain a listing of all edits and audits performed by the system on claims. Obtain or determine the processing outcome for each edit if a claim fails that edit.

3. Obtain documentation on the data entry process. Determine what edits are performed at the time of data entry.

4. Determine the point at which the transaction control number or system-assigned number is assigned to each claim. Determine how the number is assigned. For example, it might be assigned by a microfilm unit as the hardcopy is microfilmed immediately prior to data entry, or it may be assigned by programming in the data entry device.

5. Determine what dates are captured by the system. These dates should include, for example, date received, date transaction control number assigned, initial pend date, date of adjudication, and date paid.

6. Using the provider billing manuals and the list of edits obtained in Step 2, determine what data elements on each claim form are required by the system.

7. Determine what reviews are performed as a prescreening function prior to data entry. Prepare a list of reviews performed and the disposition of claims for each review step.

8. Using material previously obtained, prepare a list of possible processing outcomes or dispositions.

9. If the prior authorization process is automated, determine the processing flow, required forms, and interfaces with the claims processing system.

10. Review the lists and other documentation prepared under this section with state Medicaid claims processing specialists to ensure accuracy and completeness.

DEVELOPING THE SET OF TEST SITUATIONS

1. Review the list of test situations provided. Using state policy guidelines and other sources, identify appropriate state policy for those situations dependent on state policy.

2. During the review of test situations, determine if the State utilizes any data elements which are not included in the set of test situations. Add these data elements to the matrix, identifying appropriate claim type and probable test types.

3. Using the test material gathered, as outlined in Step 4, Other Implementation Issues, and the material and documentation gathered under the first two sections of this guide, review each claim situation in detail. This review will be most productive if performed in the implementation conference in which state policy, program, and provider specialists are in attendance. Determine for each situation: is it an appropriate test for the state; for which claim type(s) should it be used; is the expected disposition appropriate? Determine if any additional test situations are needed or desired.

4. Make changes to the set of test situations based on the results of Step 3 activities.

ESTABLISHING TEST RECIPIENTS

1. The test document has 167 cases with individuals available. Document the process for establishing new recipients. Determine how and where in this process test recipients could be interjected. Are there any variations in this process for the medically needy or other covered groups?

2. Determine the process for assigning and the structure of recipient identification numbers. Could a block of numbers be assigned to test recipients? Are family members identified? Does changing county of residence or aid program result in a new number?

3. Determine if previous periods of recipient eligibility are maintained. Can these be established retroactively as much as four months? Determine the procedure for establishing four-month continuing eligibility.

4. Determine if indications of third-party coverage are maintained on the recipient file. Determine how these indicators are maintained. For example, is Medicare coverage entered from the eligibility system process or through the BENDEX file?

5. If ID cards are generated automatically from the recipient file, determine if there is any need to suppress them for test recipients (assuming that all recipient addresses are listed as a single post office box with controlled access). Reasons for not suppressing ID card generation include need to use "sticky labels" printed as a part of the card, requirement to submit coupons with claims when coupons are a part of the ID card, or need to use plastic cards if they are used to imprint claim forms.

6. If test recipients are entered into the recipient file through the eligibility system, determine if the eligibility file is used to generate automatic monthly cash assistance payments. Determine how these payments can be prevented for test recipients.

7. Determine if a transaction turnaround document is produced when a new case is established or a change is made to an existing case. Are these automatically sent to the recipient's county of residence or state district office for verification? Determine if there is an unused or specialized county code or district for state use only which could be assigned to test recipients to prevent such deliveries. If not, investigate the feasibility of obtaining the cooperation of a nearby county or district office during the test.

8. Review the material obtained in this section with an eligibility specialist to determine accuracy or completeness. Have the eligibility specialist review each test situation to determine if any additional eligibility or enrollment issues are raised.

ESTABLISHING TEST PROVIDERS

1. The test document has 50 providers available. Document the process for enrolling new providers. Determine how and where in this process test providers could be interjected.

2. Determine the process for assigning and the structure of provider identification numbers. Is the provider number used to identify provider type? Otherwise, would a block of unused numbers be assigned to test providers? Determine how group practices, provider speciality, and categories of service are identified.

3. Determine if starting date of provider enrollment is maintained. Is this always the first day of a month? Determine if these can be established retroactively as much as five months.

4. If the provider's license number is a required data item on either the claim form or the provider file, determine how these could be safely assigned to fictitious providers. Could license board involvement be avoided? Is the provider file periodically compared to the license board file?

5. Are there any directories or listings of provider information (in addition to the provider file) which are used by claims processors?

6. If blank claim forms are automatically mailed to new providers, could this be avoided for test providers? If not, determine whether it will cause a problem.

7. Can an individual member of a group practice be placed on the provider file in an independent status if the group practice is also on file? Can a link be established between the two?

8. Determine how to monitor the account balances of test providers to ensure that all checks, if actually written, are properly received and cancelled by test personnel.

9. Is a turnaround document or file transaction report generated as a result of any additions or changes to the provider file? If so, determine how these reports could be used to verify the accuracy of data input for test providers. Determine how they could be used to monitor any unauthorized changes to these records during the test period.

10. Determine if separate accounting and physical addresses are required on the provider file. Determine which, if any, could not be a post office box. Determine what types of correspondence are sent to each.

11. Review the documentation developed under this section and the provider file from the test materials provided with a state provider enrollment specialist to determine accuracy and completeness.

12. Determine how and when IRS Form 1099s are generated. Determine how to exempt test providers from that process.

13. Evaluate the desirability of generating checks to providers. For testing purposes, checks should be generated so that test claims are processed through complete cycles. Alternatives include:

- Building a program trap to prevent test claims from entering the check-write process, yet permit production of remittance advices

- Establishing credit balances in test provider account sufficient to offset all possible payments, preventing production of checks

14. If the check generation alternative is selected, determine how to ensure that checks are mailed to the post office box. This post office box is established as the provider address and is under the control of the test coordinator. Determine what the procedure is for cancelling checks.

CALCULATING PAYMENT

1. Document the methods of reimbursement for each provider type and category of service to be included in the test. Determine if new providers are treated differently from established providers, and how they are treated differently.

2. Determine if providers, such as rural health clinics, which are paid on encounter fee are required to submit claims with usual and customary charges.

3. Determine the pricing priority for practitioners; e.g., lesser of amount billed, usual and customary, or fee schedule.

4. If providers, such as physicians, are reimbursed on the basis of usual and customary, determine how usual and customary profiles are established.

5. Determine how per diem or room rates are established for institutional providers. Are cost reports required to establish initial rates? If prospective payment systems are used, determine how the payment is calculated.

6. If state maximum fee allowances (fee schedule) are used, add those maximums to the lists of procedure codes provided in the test package.

OTHER IMPLEMENTATION ISSUES

Note: The following are issues or procedures to be resolved or performed as other procedures described in this guide are performed.

1. Compare the names of test providers to the names of real providers in the state. Change test provider names as needed.

2. Rent at least one post office box to serve as provider and recipient addresses. Boxes in two to three locations would be preferable. Because postal regulations prohibit delivery of mail to an addressee which differs from the box renter, the cooperation of the postmaster in each location should be solicited.

3. It is necessary to conduct the test without the knowledge of the individuals who process claims. There are, however, certain individuals, peripheral to claims processing, who should be aware of the test. The need for and extent of the involvement of the following should be determined early in the planning process:

    - County or district office supervisor
    - Fiscal agent manager
    - Provider relations/enrollment supervisor
    - Eligibility supervisor

4. The following materials are needed to support other planning and data gathering activities:

    - Provider claim forms
    - Recipient input form
    - Provider input form
    - Prior authorization forms
    - Sterilization consent forms
    - Claim attachments (e.g., operative reports)
    - State Plan

- Policy manuals and guidelines
- Provider billing guidelines
- Form instructions for claim forms, recipient input forms, and provider input forms
- Procedure code manual and schedules of maximum allowances
- Diagnosis code manuals
- Sample remittance advices

5. Medicaid Quality Control (MQC) samples may be taken from the Medicaid recipient file. Take steps to ensure that test recipients are not included in the MQC sample.

6. If the Medicaid recipient file is periodically compared to the eligibility file, take steps to ensure that test recipients are not purged from the recipient file.

7. If the provider file is periodically compared to license board files, take steps to ensure that test providers are not purged from the provider file.

SCHEDULING THE TEST

1. Determine the average processing time for a clean claim for each type of claim. Determine how much additional time is involved if an inquiry must be made back to the provider, or if a claim is suspended for medical review.

2. Determine the size of the current backlog in processing for each type of claim. Determine the size of the current backlog in processing suspense or error listings for each type of claim.

3. Determine how frequently recipient and provider file updates are run. Determine how long it takes to correct a data item following an update.

4. Determine how frequently claim batch processing runs are made.

5. Determine how frequently checks are generated

6. Based on the material gathered in Steps 1-5, decide on a target date for the start of the test.

POST-TEST PROCEDURES

1. Determine the procedures for purging files after the test is completed. The following files should be reviewed for the purge process:

   - Provider file
   - Recipient file
   - Eligibility file
   - Claims history file (this may include multiple files; i.e., if both the state and fiscal agent maintain a history)
   - Suspense file
   - Prior authorization file

2. Determine how to adjust BPST data out of statistical and financial reports. The reports to be considered include:

   - HCFA-420 - EPSDT Report
   - HCFA-441 - Quarterly Medicaid Workload Report
   - HCFA-350 - Report on Provider Participation
   - HCFA-2082 - Statistical Report on Medical Care
   - HCFA-64 - Quarterly expenditure report
   - CPAS reporting
   - MARS and other management and statistical reports
   - SURS and other utilization reports
   - TPL reports

APPENDIX B
CLAIMS PREPARATION EXAMPLES

To provide a better illustration of how to prepare provider claim forms for BPST testing, the following examples are provided in this appendix:

- A physician claim on the HCFA 1500 Form
- An institutional claim on the HCFA 1450 (UB-82) Form

These claims are prepared from the test situations and testing data provided in the BPST documentation. It is assumed that the provider and recipient enrollment activities have already taken place.

The presentation of the claim examples itemizes the data elements used on the form and indicates the source for BPST claim preparation. A completed claim form for a specific test is included with supporting documents cross-referenced.

Physician Claim Form (HCFA 1500)

Itemized below are the applicable data elements to BPST on the HCFA 1550 Form. The data elements are listed in order of the form locator numbers. The BPST data sources are given for each data element.

	Data Element	BPST Data Source
1.	Patient Name	Recipient Profile
2.	Patient Date of Birth	Recipient Profile
3.	Insured's Name	Recipient Profile
4.	Patient Address	If entry required, use PO Box rented for the test
5.	Patient's Sex	Recipient Profile

	Data Element	BPST Data Source
6.	Insured's Medicaid Number	Eligibility File, including test recipients
7.	Patient's Relationship to Insured	If entry required, from Recipient Profile
8.	Insured's Group Number	No entry required
9.	Other Health Insurance Coverage	Recipient Profile
10.	Was Condition Related to Accident	Answered "No," unless part of test situation
11.-18.	No entry required	
23.B	Prior Authorization Number	State specific prior authorization procedures
24.A	Dates of Service	Test situations
24.B	Place of Service	HCFA 1500 codes
24.C	Procedure Code	HCPCS codes in BPST Volume II
	Procedure Description	No entry required, can be entered to facilitate identification
24.D	Diagnosis Code	ICD-9 CM codes in BPST Volume II
24.E	Line Item Charge	State specific rate schedules
24.F	Days or Units	State specific rate schedules
24.G	Type of Service (Category of Service)	If required, Provider File
25.	Signature of Provider and Date	Signed by Test Coordinator
26.	No entry required	
27.	Total Charge	The sum of individual line amounts

	Data Element	BPST Data Source
28.	Amount Paid	No entry required, unless part of test situation
29.	Balance Due	No entry required, unless part of test situation
30.	Provider SSN	Provider Profile
31.	Provider Address	Provider Profile
32.	Patient Account Number	Test situation number
33.	Provider Employer ID	Provider Profile

The structured test situation used in the HCFA 1500 example reads as follows:

Situation Number	Claim Situation	Test Claim Characteristics
0500-H13	Concurrent hospital case for same recipient by different providers. One claim for initial visit and follow-ups; second claim for consultation and follow-ups over same period; claims in same cycle.	• 2 claims • 2 lines • Expected disposition - investigate

Claim form examples I.A and I.B show the necessary format for preparing a HCFA 1500 test claim. In the pages immediately following the claim forms, the BPST source documents from Volume II are provided. These documents contain recipient, procedure, diagnosis, provider, and test situation information relevant to the test demonstrated on the claim form. Data elements used from the source documents are cross-referenced by the HCFA 1500 form indicator numbers, located to the left of the data elements.

EXAMPLE I.A

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

☐ MEDICARE ☐ MEDICAID ☒ CHAMPUS ☐ OTHER

Form Approved OMB No 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (First name middle initial last name) Barbara K. Croissant	2 PATIENT'S DATE OF BIRTH 10 | 07 | 71 5 PATIENT'S SEX MALE [ ] FEMALE [X]	3 INSURED'S NAME (First name middle initial last name) Ellen J. Croissant 6 INSURED'S I.D. MEDICARE AND/OR MEDICAID NO (Include any letters)
4 PATIENT'S ADDRESS (Street, city, state, ZIP code) TELEPHONE NUMBER	7 PATIENT'S RELATIONSHIP TO INSURED SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]	8 INSURED'S GROUP NO (Or Group Name)
9 OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number None	10 WAS CONDITION RELATED TO A PATIENT'S EMPLOYMENT YES [ ] NO [ ] B AN ACCIDENT AUTO [ ] OTHER [ ]	11 INSURED'S ADDRESS (Street city state, ZIP code)
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) I Authorize the Release of any Medical Information Necessary to Process the Claim and Request Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below SIGNED DATE		13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT OR PREGNANCY (LMP)	15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ] 16a IF AN EMERGENCY CHECK HERE ☐
17 DATE PATIENT ABLE TO RETURN TO WORK	18 DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH
19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)		20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES

23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1 2 3 ETC OR DX CODE

A
1 Pneumonia
2
3
4

B
EPSOT YES [ ] NO [X]
FAMILY PLANNING YES [ ] NO [X]
PRIOR AUTHORIZATION NO

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G* TOS	H LEAVE BLANK
10/22/81		1	90200	Hospital visit	486.0	25 00	1	1	
10/23/81	10/25/81	1	90240	Hospital visit	486.0	60 00	3	1	

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof) SIGNED Bernard P. Harpole DATE 10/21/81	26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] NO [ ] 30 YOUR SOCIAL SECURITY NO 699-12-3450	27 TOTAL CHARGE 85 00	28 AMOUNT PAID	29 BALANCE DUE 85 00
32 YOUR PATIENT'S ACCOUNT NO 0500H13A	33 YOUR EMPLOYER I.D. NO	31 PHYSICIAN'S OR SUPPLIER'S NAME ADDRESS ZIP CODE & TELEPHONE NO Bernard P. Harpole P. O. Box XXX I.D. NO		

* PLACE OF SERVICE AND TYPE OF SERVICE (T.D.S.) CODES ON THE BACK REMARKS

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5-80
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS

Form HCFA-1500 (10-80)
Form CHAMPUS-501

EXAMPLE I.B

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

Form Approved OMB No. 0938-0008

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1 PATIENT'S NAME (First name, middle initial, last name)	2 PATIENT'S DATE OF BIRTH	3 INSURED'S NAME (First name, middle initial, last name)
Barbara K. Croissant	10 | 07 | 71	Ellen J. Croissant
4 PATIENT'S ADDRESS (Street, city, state, ZIP code) TELEPHONE NUMBER	5 PATIENT'S SEX: MALE [ ] [X] FEMALE; 7 PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [X] OTHER [ ]	6 INSURED'S I.D. MEDICARE AND/OR MEDICAID NO (Include any letters); 8 INSURED'S GROUP NO (Or Group Name)
9 OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policyholder and Plan Name and Address and Policy or Medicaid Assistance Number: None	10 WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES [ ] [ ] NO; B. AN ACCIDENT AUTO [ ] [ ] OTHER	11 INSURED'S ADDRESS (Street, city, state, ZIP code)
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) I Authorize the Release of any Medical Information Necessary to Process the Claim and to ... Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below. SIGNED ____ DATE ____		13 I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. SIGNED (Insured or Authorized Person)

PHYSICIAN OR SUPPLIER INFORMATION

14 DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT OR PREGNANCY (LMP))	15 DATE FIRST CONSULTED YOU FOR THIS CONDITION	16 HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] [ ] NO	16a IF AN EMERGENCY CHECK HERE ☐
17 DATE PATIENT ABLE TO RETURN TO WORK	18 DATES OF TOTAL DISABILITY FROM ____ THROUGH ____	DATES OF PARTIAL DISABILITY FROM ____ THROUGH ____	
19 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)		20 FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED ____ DISCHARGED ____	
21 NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		22 WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] [ ] NO CHARGES	
23 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC OR DX CODE. A 1 2 3 4		B EPSDT YES [ ] NO [X]; FAMILY PLANNING YES [ ] NO [X]; PRIOR AUTHORIZATION NO ____	

24 A DATE OF SERVICE FROM	TO	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G* TOS	H LEAVE BLANK
10/22/81		1	90600		486.0	30 00	1	1	
10/23/81	10/25/81	1	90240		486.0	60 00	3	1	

25 SIGNATURE OF PHYSICIAN OR SUPPLIER (I certify that the statements on the reverse apply to this bill and are made a part hereof)	26 ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES [ ] [ ] NO	27 TOTAL CHARGE 90 00	28 AMOUNT PAID	29 BALANCE DUE 90 00
SIGNED Donald McGreevey MD DATE	30 YOUR SOCIAL SECURITY NO 699-10-3171	31 PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO McGreevey, Donald		
32 YOUR PATIENT'S ACCOUNT NO 0500H13A	33 YOUR EMPLOYER I.D. NO	I.D. NO		

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS

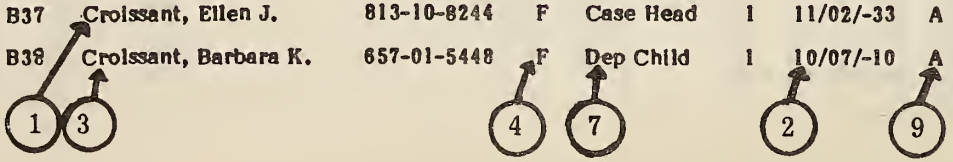
APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-80
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS

Form HCFA-1500 (10-80)
Form CHAMPUS-501

EXAMPLES I.A AND I.B SOURCE DOCUMENT

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B20	Bishop, Roger C.	637-06-5761	M	Dep Child	1	10/14/-11	A	AFDC-CN	
B21	Biwer, Bengamin M.	942-10-3740A	M	Case Head	3	12/16/-68	B	OAA-CN	
B22	Borrero, Maria R.	898-08-0267	F	Case Head	1	05/23/-28	A	AFDC- CN	
B23	Borrero, Louise P.	606-10-6574	F	Dep Child	1	10/12/-04	A	AFDC-CN	
B24	Brewer, Evelyn L.	973-01-9610B	F	Case Head	2	12/17/-67	A	OAA-CN	
B25	Browne, Bernice A.	936-02-1321B	F	Case Head	2	02/06/-66	A	OAA-CN	
B26	Buford, Cynthia R.	827-03-3798	F	Case Head	1	02/27/-35	A	AFDC-CN	
B27	Buford, Jerry D.	663-05-9922	M	Dep Child	1	08/14/-08	A	AFDC-CN	
B28	Burford, Thelma N.	606-07-4326	F	Dep Child	1	12/02/-17	A	AFDC-CN	
B29	Caldwell, Leona E.	879-09-0614	F	Case Head	1	05/11/-29	A	AFDC-CN	
B30	Caldwell, Jack C.	615-02-3003	M	Dep Child	1	03/23/-09	A	AFDC-CN	
B31	Caleen, Connie J.	913-01-7156B	F	Case Head	4	03/05/-65	A	OAA-CN	
B32	Chivers, Myrtle K.	833-04-8005	F	Case Head	1	02/19/-37	B	AFDC-MN	
B33	Chivers, Edward S.	617-06-8356	M	Dep Child	1	09/15/-17	B	AFDC-MN	
B34	Collins, Mary J.	842-08-9873A	F	Case Head	3	01/21/-62	A	APTD-CN	
B35	Cole, Gene R.	922-04-8561A	M	Case Head	2	04/11/-67	A	OAA-CN	
B36	Cooper, Coris D.	976-03-8470D	F	Case Head	2	05/13/-66	A	OAA-CN	Change ID +25
B37	Croissant, Ellen J.	813-10-8244	F	Case Head	1	11/02/-33	A	AFDC-CN	
B38	Croissant, Barbara K.	657-01-5448	F	Dep Child	1	10/07/-10	A	AFDC-CN	



EXAMPLES I.A AND I.B SOURCE DOCUMENT

PROCEDURE CODES

HCPCs Code	Description	State Code
80005	Automated multichannel test; 5 clinical chemistry tests	
81000	Urinalysis, routine, with microscopy	
81005	Urinalysis, chemical, qualitative	
81099	Unlisted urinalysis procedure	
82100	Alkaloids, urine; screening	
82245	Bile pigments urine	
85022	Blood Count, hemogram, automated	
85031	Blood count, hemogram, manual complete CBC	
88150	Cytopathology smears (e.g., Papanicolaou)	
90010	Office visit, limited, new patient	
90015	Office visit, intermediate, new patient	
90017	Office visit, extended, new patient	
90020	Office visit, comprehensive, new patient	
90040	Office visit, brief, established patient	
90050	Office visit, limited, established patient	
90060	Office visit, intermediate, established patient	
90100	Home visit, brief, new patient	
90150	Home visit, limited, established patient	
(24C)→ 90200	Hospital visit, brief, initial care	
90215	Hospital visit, intermediate, initial care	
90240	Hospital visit, brief, subsequent care	

EXAMPLE I.A AND I.B. SOURCE DOCUMENT

ICD-9-CM DIAGNOSIS CODES

ICD-9-CM Code	Description
379.90	Unspecified disorder of eye
380.10	Infective otitis externa, unspecified
388.70	Otalgia, unspecified
389.10	Sensorineural hearing loss, unspecified
389.11	Sensory hearing loss
415.1	Pulmonary embolism and infarction
427.9	Cardiac dysrhythmia, unspecified
428.1	Left heart failure
428.9	Heart Failure, unspecified
429.0	Myocarditis, unspecified
429.2	Cardiovascular disease, unspecified
455.5	External hemorrhoids with other complication
459.0	Hemorrhage, unspecified
460	Acute nasopharyngitis
462	Acute pharyngitis
463	Acute Tonsillitis
474.10	Hypertrophy of tonsils and adenoids
480.9	Viral pneumonia, unspecified
(24D)→486	Pneumonia, organism unspecified
487.1	Influenza with other respiratory manifestations
487.8	Influenza with other manifestations
490	Bronchitis
524.9	Unspecified dentofacial anomalies

EXAMPLE I.A SOURCE DOCUMENT

PROVIDER PROFILE

Sequence No.: 30

(31) Provider Name: Harpole, Bernard P. Title: MD

(30) Social Security No.: 699-12-3450 Enrollment Date: 0

Employer Identification No.: _____ Board Certification Date: _____

License Number: _____ Board Certification Code: _____

Provider Type: 40-Physician

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
136	Family/General	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: _____ Individual/Group Number: 12-Metropolitan

Address: _____

County: _____ Telephone No.: _____

EXAMPLE I.A. AND I.B. SOURCE DOCUMENT

STRUCTURED TEST SITUATIONS

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	No. Claims	No. Lines	No. Cycles	Expected Disposition
0500-H11	Four claims for different procedures that are improbable on the same day for the same recipient (e.g., four different diagnoses — cold, ascites, congestive heart failure, and false labor); two claims in one cycle; two in the next.				4	1	2	Investigate
0500-H12	Procedures incidental to major surgery (e.g., biopsy, endoscopy, more than one procedure in an incision) performed by same physician.				1	2	1	Reduce and pay
32 → 0500-H13	Concurrent hospital care for same recipient by different providers. One claim for initial visit and follow-ups; second claim for consultation and follow-ups over same period. Claims in same cycle.				2	2	1	Investigate
0500-H14	Claims for major surgery and associated post-operative care, performed by same physician; post-care occurs during follow-up period. Claims in different cycles.				2	1	2	Deny second

EXAMPLE I.B SOURCE DOCUMENT

PROVIDER PROFILE

Sequence No.: 28

31 → Provider Name: McGreevey, Donald P. Title: MD

30 → Social Security No.: 699-10-3171 Enrollment Date: 0

Employer Identification No.: Board Certification Date:

License Number: Board Certification Code:

Provider Type: 40-Physician

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
141	Internal Medicine	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: Individual/Group Number: 11-Columbia Medical

Address:

County: Telephone No.:

Institutional Claim Form (HCFA 1450/UB-82)

Below are the BPST applicable data elements on the HCFA 1450/UB-82 Form. The data elements are listed in order of the form locator numbers. The BPST data sources are given for each data element.

	Data Element	BPST Data Source
1.	Provider Name, Address, Telephone Number	Provider Profile
2.	No entry required	
3.	Provider - Patient Control Number	Test situation number
4.	Type of Bill	Test situations (UB-82 codes)
5.-7.	No entry required	
8.	Medicaid Provider Number	State Medicaid Provider File, including test providers
9.	No entry required	
10.	Patient Name	Recipient Profile
11.	Patient Address	Recipient Profile
12.	Patient Birthdate	Recipient Profile
13.	Patient Sex	Recipient Profile
14.	No entry required	
15.	Admission Date	Test situations
16.	No entry required	
17.	Type of Admission	Test situations (UB-82 codes)
18.	Source of Admission	Test situations (UB-82 codes)
19.-20.	No entry required	

	Data Element	BPST Data Source
21.	Patient Status	Test situations (UB-82 codes)
22.	Statement Covers Period	Test situations
23.-27.	No entry required	
28.-32.	Occurrence Codes and Data	Test situations (UB-82 codes)
33.	Occurrence Span Codes and Dates	Test situations (UB-82 codes)
34.	Responsible Party Name and Address	Provider Profile
35.-39.	Condition Codes	Test situations (UB-82 codes)
40.-49.	No entry required	
50.	Revenue Description	Test situations (UB-82 state abbreviations)
51.	Revenue Codes	Test situations (UB-82 codes)
52.	Units of Service	Test situations
53.	Total Charges	State-specific rate schedules
54.	Non-covered	No entry required, unless part of test situation
55.-56.	No entry required	
57.	Payor Identification	"Medicaid" unless otherwise indicated in test situations
58.-59.	No entry required	
60.	Deductible	No entry required, unless part of test situations

	Data Element	BPST Data Source
61.	Co-Insurance	No entry required, unless part of test situations
62.	Estimated Responsibility	No entry required, unless part of test situation
63.	Prior Payments	No entry required, unless part of test situations
64.	Estimated Amount Due	No entry required, unless part of test situations
65.	Insurer's Name	Required only if Medicaid is not the primary payor in test situation
66.	No entry required	
67.	Patient's Relationship to Insured	Recipient Profile
68.	Medicaid Identification Number	State-specific eligibility file, including test recipients
69.-75.	No entry required	
76.	Principal and Other Diagnoses Descriptions	ICD-9-CM descriptions
77.	Principal Diagnosis Code	ICD-9-CM codes
78.-81.	Other Diagnoses Codes	If applicable, ICD-9-CM codes
82.	No entry required	
83.	Principal and Other Procedure Descriptions	No entry required
84.	Principal Procedure Code and Date	HCPCS or CPT IV, depending on Provider Type
85.-86.	Other Procedure Codes and Dates	No entry required, unless part of test situation

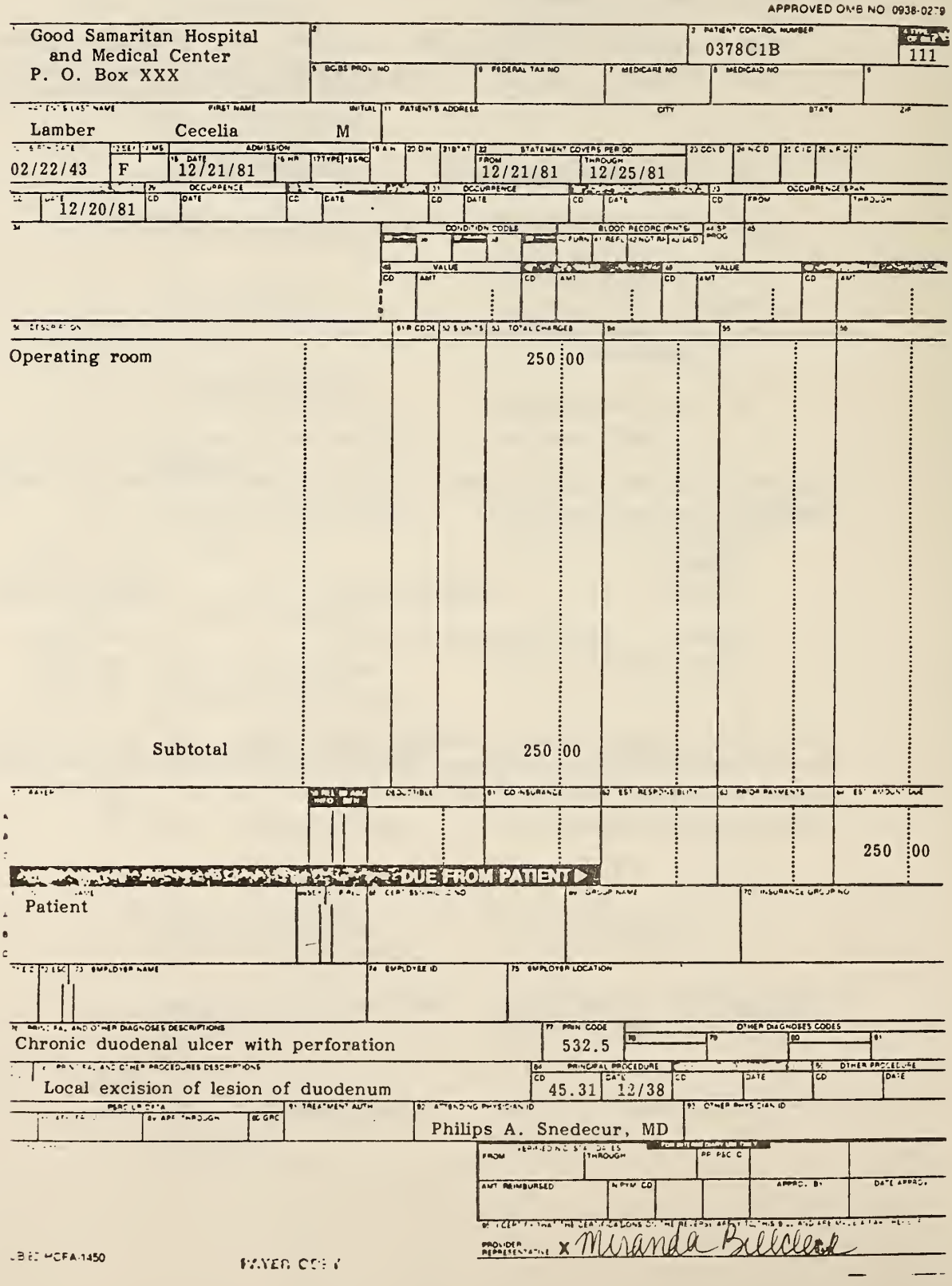
	Data Element	BPST Data Source
87.-90.	No entry required	
91.	Treatment Authorization Code	No entry required, unless a prior approval test in which case the code is from the State-specific PA assignment process
92.	Attending Physician ID	Provider Profile
93.	Other Physician ID	If necessary, Provider Profile
94.	No entry required	
95.	Provider Representative Signature	Signed by the BPST Coordinator
96.	Date Bill Submitted	Test situation

The structured test situation used in the HCFA 1450/UB-82 example reads as follows:

Situation Number	Claim Situation	Test Claim Characteristics
0378-C	Date of surgery not valid	• One claim • One line • One cycle

Claim form Examples II is a completed BPST HCFA 1450/UB-82 test claim for the above-listed test situation. Applicable BPST source documents from Volume II are cross-referenced by form locator number to the test claim.

EXAMPLE II



APPROVED OMB NO 0938-0279

Good Samaritan Hospital
and Medical Center
P. O. Box XXX

3 PATIENT CONTROL NUMBER: 0378C1B
4 TYPE OF BILL: 111

Lamber | Cecelia | M

3 BIRTH DATE: 02/22/43
4 SEX: F
5 ADMISSION DATE: 12/21/81
22 STATEMENT COVERS PERIOD: FROM 12/21/81 THROUGH 12/25/81
31 OCCURRENCE DATE: 12/20/81

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	Operating room				250 00	
	Subtotal				250 00	

50 PAYER: Patient
51 HEALTH PLAN ID
52 REL TO INSD
53 ASSIGN OF BEN
54 PRIOR PAYMENTS
55 EST AMOUNT DUE: 250 00
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 INSURANCE GROUP NAME
62 INSURANCE GROUP NO
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 EMPLOYER ID
67 EMPLOYER LOCATION
67A PRINCIPAL DIAGNOSIS CODE
68 ADMITTING DIAGNOSIS CODE
69 PATIENT REASON DIAGNOSIS CODE
70 PRINCIPAL PROCEDURE (PROC CODE / DATE)
71 OTHER PROCEDURE (PROC CODE / DATE)
72 ATTENDING PHYSICIAN ID
73 OTHER PHYSICIAN ID
74 REMARKS

DUE FROM PATIENT ▶ 250 00

76 PRINC DIA AND OTHER DIAGNOSES DESCRIPTIONS
Chronic duodenal ulcer with perforation

77 PRIN CODE: 532.5

OTHER DIAGNOSES CODES: 78 | 79 | 80 | 81

84 PRINCIPAL PROCEDURE: CD 45.31 | DATE 12/38

85 OTHER PROCEDURE: CD | DATE | CD | DATE

76 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS
Local excision of lesion of duodenum

PRSC LR DATA: 87 APR THROUGH | 88 GRC

89 TREATMENT AUTH

90 ATTENDING PHYSICIAN ID
Philips A. Snedecur, MD

91 OTHER PHYSICIAN ID

92 REMARKS STATE USE: FROM | THROUGH | PP PSC C
AMT REIMBURSED | N PYM CD | APPRO. BY | DATE APPRO.

I CERTIFY THAT THE CHARGES ON THIS BILL ARE MADE FOR SERVICES RENDERED TO THE PATIENT NAMED HEREIN
PROVIDER REPRESENTATIVE x Miranda Billclerk

UB-82 HCFA-1450

PAYER CODE

EXAMPLE II SOURCE DOCUMENT

PROVIDER PROFILE

Sequence No.: 2

1 → Provider Name: Good Samaritan Hosp. & Medical Ctr. Title: _____

Social Security No.: _____ Enrollment Date: 0

Employer Identification No.: _____ Board Certification Date: _____

License Number: _____ Board Certification Code: _____

Provider Type: 50-Hospital

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
650	Acute Care	16	Inpatient
		17	Outpatient
		18	Emergency
		19	Mental Health

Rate Data:

Code	Rate	Effective Date
Rate		0

Assigned Provider No.: _____ Individual/ Group Number: _____

Address: _____

County: _____ Telephone No.: _____

EXAMPLE II SOURCE DOCUMENT

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	No. Claims	No. Lines	No. Cycles	Expected Disposition
378	DATE OF SURGERY							
3 → 378-C	Date of surgery not valid (see standard validity date checks).				1	1	1	Return or deny
378-D1	No date of surgery; procedure indicates surgery was performed.				1	1	1	Return or deny
378-D2	Date of surgery indicated, but no surgical procedure included.				1	1	1	Investigate
378-E	Excess time between date of surgery and admission date.	Depends on state policy.			1	1	1	Investigate
379	LEAVE DAYS							
379-F	Leave days exceed maximum number allowed. Could include therapeutic leave or hospitalization or both.	Applicable to states which allow reimbursement for leave days.		LTC provider	1	1	1	Reduce and pay
380	ALLOWABLE PROCEDURE AMOUNT							
380-C1	Amount billed is less than all other pricing amounts.				1	1	1	Pay amount billed.
380-C2	Fee schedule is less than amount billed, UCR amount, and area prevailing.				1	1	1	Pay fee schedule amount.

EXAMPLE II SOURCE DOCUMENT

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B58	Gilligan, Gary B.	693-06-8391	M	Dep Child	1	11/26/-14	A	AFDC-CN	
B59	Gonzalez, Godfrey J.	989-02-5014B1	M	Case Head	3	10/19/-66	A	OAA-CN	
B60	Graham, Betty S.	668-08-8973	F	Case Head	1	11/21/-30	A	AFDC-CN	
B61	Graham, Ben F.	629-10-9024	M	Dep Child	1	07/21/-10	A	AFDC-CN	
B62	Haggard, Ramona T.	894-01-1248	F	Case Head	1	06/16/-35	A	AFDC-CN	
B63	Haggard, Richard L.	619-03-8299	M	Dep Child	1	07/13/-15	A	AFDC-CN	
B64	Harden, Clayton A.	971-04-2530A	M	Case Head	2	03/24/-69	A	OAA-CN	
B65	Himelhoch, Nellie B.	625-05-7170	F	Case Head	1	06/04/-37	A	AFDC-MN	
B66	Himelhoch, Joe H.	676-07-2672	M	Dep Child	1	05/17/-17	A	AFDC-MN	
B67	Hobbs, Linda T.	911-06-1596A	F	Case Head	2	06/07/-67	A	OAA-CN	
B68	Imeson, Shirley S.	812-09-6403	F	Case Head	1	04/08/-27	A	AFDC-CN	
B69	Imeson, George W.	619-02-7892	M	Dep Child	1	12/21/-17	A	AFDC-CN	
B70	Jacobs, Jerome T..	968-08-2583A	M	Case Head	3	01/29/-68	B	OAA-CN	
B71	Johnson, Margaret A.	653-04-8554	F	Case Head	1	11/27/-40	A	AFDC-CN	
B72	Johnson, Lee F.	616-06-5234	F	Dep Child	1	10/20/-04	A	AFDC-CN	
B73	Kendrick, Irene C.	895-08-0001	F	Case Head	1	07/26/-27	A	AFDC-CN	
B74	Kendrick, Anita A.	625-10-9530	F	Dep Child	1	01/14/-05	A	AFDC-CN	
B75	Kim, Ryan A.	922-10-2967	M	Case Head	1	02/01/-66	A	OAA-CN	
(10) → B76	Lambert, Cecelia M.	864-01-1726	F	Case Head	1	02/22/-38	B	AFDC-CN	

EXAMPLE II SOURCE DOCUMENT

ICD-9-CM Code	Description
525.8	Other disorders of teeth and supporting structures
525.9	Unspecified disorder of teeth and supporting structures
528.8	Oral submucosal fibrosis
531.9	Gastric ulcer without mention of hemorrhage or perforation
532.0	Acute duodenal ulcer with hemorrhage
(77) → 532.5	Chronic Duodenal ulcer with perforation
540	Acute appendicitis
540.9	Acute appendicitis without mention of peritonitis
541	Appendicitis, unqualified
553.1	Umbilical hernia
562.11	Diverticulitis of colon
569.42	Anal or rectal pain
569.83	Perforation of intestine
599.1	Urethral fistula
599.6	Urinary obstruction, unspecified
599.7	Hematuria
601.1	Inflammatory disease of prostate
610.0	Solitary cyst of breast
615.1	Chronic inflammatory disease of uterus
617.2	Endometriosis of fallopian tube
621.5	Intrauterine synechiae
625.2	Mittelschmerz
627.0	Premenopausal menorrhagia

EXAMPLE II SOURCE DOCUMENT

ICD-9-CM PROCEDURE CODES FOR INPATIENT HOSPITAL CLAIMS

ICD-9-CM Code	Description	CPT-4 Code
28.2	Tonsilectomy without adenoidectomy	42825 42826
28.3	Tonsilectomy with adenoidectomy	42820 42821
39.98	Control of hemorrhage	*
40.23	Excision of axillary lymph node	38500
(84) 45.31	Local excision of lesion of duodenum	44110
47.0	Appendectomy	44950
60.11	Needle biopsy of prostate	55700
66.39	Transection of fallopian tube	58600
68.4	Total abdominal hysterectomy	58150
69.98	Other operations on supporting structures of uterus	*
72.9	Unspecified instrumental delivery (obstetric)	59410
73.59	Other manually assisted delivery	59410
74.0	Classical Cesarean section	59520
83.42	Other tenonectomy	*
85.53	Unilateral breast implant	19310
87.17	Other X-ray of skull	70250
94.38	Supportive verbal psychotherapy	90841
94.39	Other individual psychotherapy	90841
99.02	Autotransfusion of whole blood	86128

EXAMPLE II SOURCE DOCUMENT

PROVIDER PROFILE

Sequence No.: 33

92 → Provider Name: Snedecor, Phillip A. Title: MD

Social Security No.: 699-15-0452 Enrollment Date: 0

Employer Identification No.: _____ Board Certification Date: _____

License Number: _____ Board Certification Code: _____

Provider Type: 40-Physician

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
160	Surgery, General	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: _____ Individual/ Group Number: _____

Address: _____

County: _____ Telephone No.: _____

U.S. Department of
Health and Human Services
Health Care Financing Administration

Medicaid Bill Processing System Test Implementation Documentation

Volume II - BPST Test Package

December 1986

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID BILL PROCESSING SYSTEMS TEST

IMPLEMENTATION DOCUMENTATION

VOLUME II - BPST TEST PACKAGE

December 1986

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CHAPTER I
FUNCTIONS AND FEATURES CHECKLIST

The functions and features listed on this chart are the minimal requirements for a certified MMIS. These functions and features are those listed in the State Medicaid Manual, Part 11 for claims processing subsystems. The appropriate test mechanism for each is identified.

FUNCTIONS AND FEATURES CHECKLIST

Subsystem: Claims Processing Subsystem

Number	Function and Feature	Structured Data Test	General Control Test	Output Test	Comments
	The Claims Processing Subsystem must accomplish the following objectives:				
A1	Ensure that all input into the subsystem is captured at the earliest possible time and in an accurate manner.	X	X		
A2	Establish control over all transactions during their entire processing cycle.		X		
A3	Verify that all providers submitting input are properly enrolled.	X			
A4	Ensure that all recipients for whom input is submitted were eligible for the type of service at the time the service was rendered.	X			
A5	Ensure that all input submitted to the subsystem is processed completely.	X			
A6	Verify that charges submitted by providers are reasonable and within acceptable limits.	X			
A7	Ensure that reimbursements to providers are rendered promptly and correctly.			X	
A8	Maintain accurate and complete registers and audit trails of all processing.			X	

FUNCTIONS AND FEATURES CHECKLIST

Subsystem: Claims Processing Subsystem

Number	Function and Feature	Structured Data Test	General Control Test	Output Test	Comments
A9	Maintain all processed data necessary to satisfy legal requirements and the needs of other subsystems.		X		
A10	Respond to queries concerning recipient eligibility and benefit status.		X		
A11	Process approved prior authorization requests.	X			
A12	Process provider credits and adjustments.	X			
	Techniques will be implemented to perform the following:				
B1	Uniquely identify and locate any provider claim.		X	X	
B2	Automatically suspend all transactions in error until corrections are made.		X		
B3	Check each claim prior to payment against all current and previously paid claims for which a duplicate payment could exist.	X			
B4	Provide a prompt response to all inquiries regarding the status of any claim.		X		

FUNCTIONS AND FEATURES CHECKLIST

Subsystem: Claims Processing Subsystem

Number	Function and Feature	Structured Data Test	General Control Test	Output Test	Comments
	The Claims Processing Subsystem will be designed to ensure:				
C1	Adjudication for payment within 30 days after:				
	a. Receipt of any properly submitted correct claim which passes all required edits and checks		X		
	b. Correction of any error condition(s) preventing payment which is attributable to the provider		X		
	c. Correction of any error condition(s) preventing payment which is attributable to the agency or its system or its data		X		
	d. Correction of any condition(s) preventing payment which is beyond the agency's control.		X		
C2	Issuance of remittance statements to providers detailing claims and services covered by a given payment at the same time as the payment.			X	
C3	Provide EOB individual notices, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the State Plan.			X	
	The Claims Processing Subsystem will identify claims paid for all services covered by the State Plan, including:				
D1	Early and Periodic Screening, Diagnosis, and Treatment	X			
D2	Family Planning Services	X			

FUNCTIONS AND FEATURES CHECKLIST

Subsystem: Claims Processing Subsystem

Number	Function and Feature	Structured Data Test	General Control Test	Output Test	Comments
D3	Medicare deductibles and coinsurance paid by Medicaid	X			
E1	The Claims Processing Subsystem must have the capability to identify, by recipient, the screening and related diagnosis and treatment services.	X			
G1	The Claims Processing Subsystem must have the ability to identify third party liability and ensure that the Title XIX program is the payor of last resort.	X			

CHAPTER II
DATA ELEMENT MATRIX

The data elements selected are taken from the MMIS GSD (Blue Books) and from additions to the GSD for Long-Term Care and EPSDT.

The data elements are identified as to their input source (claim form). The matrix identifies those data elements which are system generated and the source subsystem.

For each data element, a set of test types have been identified. The definitions of each of these test types are shown on the next page.

TEST TYPE DEFINITIONS

Test Type	Code	Meaning
Presence	A	Data element must be present, if required.
Format	B	Data element has specific format (alphabetic or numeric).
Validity	C	Data element must be one of a set of predefined values.
Consistency	D	Data element must be logically consistent with one or more other data elements within the same input transaction.
Reasonableness	E	Data element which must fall within a range of reasonable values (e.g., high/low dollar values).
Benefit Limit	F	Data element(s) must conform to a defined service limitation policy.
Duplication	G	Data element(s) which is a key item must not be a duplicate.
Conflict	H	Data element(s) in a transaction must be logically consistent with current file data within the subsystem.

HEALTH CARE FINANCING ADMINISTRATION

BILL PROCESSING SYSTEMS TEST (BPST)

DATA ELEMENT MATRIX

Test Types: Subsystem (System Generated DEs)	No Edit	Conflict	Duplication	Benefit and Policy-Related Limitations	Reasonableness	Consistency	Validity	Format	Presence	DATA ELEMENT DESCRIPTION: DE No.	Data Element Name	Input Sources: HCFA-1500	HCFA-1450 - Inpatient	HCFA-1450 - Outpatient	LTC Turnaround Document	Pharmacy Claim Form	Transportation Claim Form	Dental Claim Form	EPSDT Screening Form	Prior Authorization Form	Adjustment Request Form	EMC Billing	Tape Crossover	System Generated
									A	0000	Preprocessing	X	X	X	X	X	X	X	X	X	X			
E	J					D	C	B	A	0101	Recipient ID Number	X	X	X	X	X	X	X	X	X	X	X	X	
										0103	Recipient Name	X	X	X	X	X	X	X	X	X		X		X
E				F		D	C			0105	Recipient Date of Birth	X	X	X	X	X	X	X	X			X		
E				F						0107	Recipient Sex Code													X
E				F						0109	Recipient Aid Category													X
E		H				D				0113	Third Party Liability Code													X
E						D				0114	Buy-In Status Code													X
E						D				0116	Recipient Exception Indicator													X
E						D				0118	Medicare Type Code													X
E	J					D	C		A	0201	Provider Number	X	X	X	X	X	X	X	X			X		
P						D				0205	Provider Type	X	X	X	X	X	X	X	X			X		X
P						D	C			0209	Provider Group Number	X						X	X			X		X
P							C			0225	Provider Exception Indicator													
P					E					0226	Provider Credit Balance Amt.													X
P		H								0233	Provider-Specific Rate													X
P		H								0234	Percent of Charges Factor													X
P		H								0235	Rate Effective Date													X
P		H								0238	Provider Enrollment Status Code													X
C			G				C	B	A	0300	Transaction Control No.													
						D	C			0301	Category of Service													X
						D	C		A	0303	Attending Physician No.		X	X								X	X	
						D	C			0304	Referring Physicain No.	X	X	X				X	X			X	X	
							C		A	0305	Prescribing Physician No.	X				X						X		

HEALTH CARE FINANCING ADMINISTRATION

BILL PROCESSING SYSTEMS TEST (BPST)

DATA ELEMENT MATRIX

DATA ELEMENT DESCRIPTION

DE No.	Data Element Name	Test Types: Subsystem (System Generated DEs)					No Edit		Conflict	Duplication	Benefit and Policy-Related Limitations	Reasonableness	Consistency	Validity	Format	Presence	Input Sources: HCFA-1500	HCFA-1450 - Inpatient	HCFA-1450 - Outpatient	LTC Turnaround Document	Pharmacy Claim Form	Transportation Claim Form	Dental Claim Form	EPSDT Screening Form	Prior Authorization Form	Adjustment Request Form	EMC Billing	Tape Crossover	System Generated
0306	Primary Diagnosis Code	P					J		H		F	E	D	C	B	A	X	X	X		X	X	X	X			X	X	
0307	Secondary Diagnosis Code						J		H		F	E	D	C	B		X	X	X		X	X	X	X			X	X	
0310	Billing Date								H				D	C			X	X	X	X	X	X	X				X	X	
0311	Admission Date								H		F		D	C		A	X	X	X	X	X	X	X	X	X	X	X	X	
0312	Beginning Date of Service								H		F		D	C		A	X	X	X	X	X	X	X	X	X	X	X	X	
0313	Ending Date of Service								H				D	C			X	X	X	X	X	X	X	X	X	X	X	X	
0314	Place of Service										F		D	C	B		X	X	X	X	X	X	X	X	X	X	X	X	
0315	Refill Indicator											E			B		X	X	X	X	X	X	X	X	X	X	X	X	
0316	Patient Status												D	C	B	A	X	X	X	X	X	X	X	X	X	X	X	X	
0317	Discharged Patient's								H				D				X	X	X	X	X	X	X	X	X	X	X	X	
0318	Destination Provider No.						J						D				X	X	X	X	X	X	X	X	X	X	X	X	
0319	Previous Provider No.						J										X	X	X	X	X	X	X	X	X	X	X	X	
0320	Patient Account No.								H			E	D		B	A	X	X	X	X	X	X	X	X	X	X	X	X	
0321	Total Claim Charge								H		F	E	D	C	B	A	X	X	X	X	X	X	X	X	X	X	X	X	
0322	Procedure Charge								H		F		D	C	B	A	X	X	X	X	X	X	X	X	X	X	X	X	
0323	Drug Charge								H		F		D	C	B	A	X	X	X	X	X	X	X	X	X	X	X	X	
0326	Blood Not Replaced										F	E	D		B		X	X	X	X	X	X	X	X	X	X	X	X	
0327	Units of Service						J										X	X	X	X	X	X	X	X	X	X	X	X	
0328	Third Party Action Code								H				D	C			X	X	X	X	X	X	X	X	X	X	X	X	
0329	Third Party Payment Amount								H				D				X	X	X	X	X	X	X	X	X	X	X	X	
0330	Medicare Deductible Amt.												D				X	X	X	X	X	X	X	X	X	X	X	X	
0331	Medicare Blood Deductible												D				X	X	X	X	X	X	X	X	X	X	X	X	
0332	Medicare Coinsurance Amt.												D				X	X	X	X	X	X	X	X	X	X	X	X	
0333	Medicare Coinsurance Days																X	X	X	X	X	X	X	X	X	X	X	X	
0335	Adjustment Amount								H				D					X								X			

HEALTH CARE FINANCING ADMINISTRATION

BILL PROCESSING SYSTEMS TEST (BPST)

DATA ELEMENT MATRIX

DATA ELEMENT DESCRIPTION

| Test Types | | |

HEALTH CARE FINANCING ADMINISTRATION

BILL PROCESSING SYSTEMS TEST (BPST)

DATA ELEMENT MATRIX

DATA ELEMENT DESCRIPTION

DE No.	Data Element Name	HCFA-1500	HCFA-1450 - Inpatient	HCFA-1450 - Outpatient	LTC Turnaround Document	Pharmacy Claim Form	Transportation Claim Form	Dental Claim Form	EPSDT Screening Form	Prior Authorization Form	Adjustment Request Form	EMC Billing	Tape Crossover	System Generated
0423	Employment Related Indicator	X				X						X		
0430	Days' Supply of Drug					X						X		
0500	Procedure Code	X		X				X				X	X	
0501	Drug Code				X	X						X		
0513	Prus Unit of Measure				X									
1545	NH Level of Care				X									
1546	Patient Liability													

Input Sources

Test Types

Subsystem (System Generated DEs)	Presence	Format	Validity	Consistency	Reasonableness	Benefit and Policy-Related Limitations	Duplication	Conflict		No Edit				
	A	B	C	D	E	F	G	H						
	A	B	C	D	E	F	G							
	A	B	C	D			C							

CHAPTER III
STANDARD TEST SITUATIONS

The following list identifies the standard set of BPST test situations, cross-referenced to the functions and features (F & F) matrix. Where needed, the unique recipient, provider, and service characteristics are identified for each test situation.

The test situation numbering scheme, which can also be used for test claim numbering, is defined on the next page.

TEST CLAIM SITUATION NUMBERING SCHEME

Format 999-X99-X

9999 Data element number using the MMIS numbering system shown in the Volume II Data Element Matrix.

X99 * "X" is the type of edit being performed for the data element.

"99" is the sequential situation number for a given type of edit with a data element number.

X ** Input source (claim type)

* Type of Edit	** Input Source (Claim Type)
A - Presence	A - HCFA-1500
B - Format	B - UB-82
C - Validity	C - Transportation
D - Consistency	D - Dental
E - Reasonableness	E - Home Health
F - Benefit Limitation	F - Nursing Home
G - Duplication	G - Adjustment
H - Conflict	B - HCFA-1450 (UB82)-Inpatient
	C - HCFA-1450 (UB82)-Outpatient
	D - LTC Turnaround Document
	E - Pharmacy
	F - Transportation
	G - Dental
	H - EPSDT Screening Invoice
	I - Prior Authorization
	J - Adjustment

Note: EMC billings and tape crossovers will use the same claim type indicators as paper claims.

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0000	PREPROCESSING						
0000-A	PRESENCE TESTS						
0000-A1	Signature of provider or preparer is missing					A9	Return
0000-A2	Claim for procedure requiring written report (e.g., operative report) and report is missing	May be either a pre-screening test or a data entry test		Physician	By report procedure	A9	Return or deny
0000-A3	Claim for sterilization and consent form is missing	Consent form required; procedure must match sex	Recipient over 21		Sterilization	A9	Return or deny
0000-A4	Claims for sterilization with consent form but date of consent is missing	Consent form required; procedure must match sex. (See 0417-A)	Recipient over 21		Sterilization	A9	Deny
0000-A5	Claim for sterilization with consent form but recipient signature is missing	Consent form required; procedure must match sex	Recipient over 21		Sterilization	A9	Deny
0000-A6	EPSDT claim missing the required number of examinations			Physician	EPSDT screening	D1	Return or deny
0000-A7	Claim missing proof of eligibility (e.g. "sticky" label, coupon, or copy of eligibility ID card)	Where required by state procedure				A9	Deny
0101	RECIPIENT ID NO.						
0101-A	Recipient ID number is missing					A1	Return or deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0101-B	Recipient ID is not proper format	Use if ID has imbedded codes,				A1	Return or deny
0101-C1	Recipient ID is not on file					A4	Recycle and deny
0101-D1	Recipient not eligible on date of service					A4	Deny
0103	RECIPIENT NAME						
0105	RECIPIENT DATE OF BIRTH	Birthdate may be provided by Recipient Subsystem					
0105-C	Birthdate is not valid date (see standard validity date checks)					A1	Return or deny
0105-D2	Claim for recipient over age 65, no indication of Medicare coverage	Automatic "buy-in" initiated	Non-Medicare recipient over 65			G1	Pay and report
0105-F1	Sterilization claim for recipient under 21 years of age		Recipient under 21		Sterilization	A9	Deny
0105-F2	Screening services for recipient over 21 years age		Recipient over 21	Physician	EPSDT screening service	A9	Deny
0105-F3	Treatment in a tuberculosis facility for recipient under 65 years of age	Depends on state policy	Recipient under 65	Tuberculosis facility	Inpatient	A9	Deny
0105-F4	Claim is for psychiatric treatment in a state institution for recipient under 65 years of age	Depends on state policy	Recipient under 65 years of age and over 21	State mental institution	Inpatient	A9	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0105-F5	Claim is for psychiatric treatment for recipient under 21 years of age	Depends on state policy	Recipient under 21 years of age		Psychiatric service	A9	Pay
0105-F6	SNF level of care; recipient under 21 years of age	Depends on state policy	Recipient under 21 years of age	Nursing home (SNF)	Inpatient	A9	Deny
0105-F7	Dental claim for prophylaxis; recipient over age 21	Depends on state policy	Recipient under 21 years of age	Dentist	Dental prophylaxis	A9	Return or deny
0107	RECIPIENT SEX CODE	Sex code may be provided by Recipient Subsystem					
0107-F1	Claim for procedure limited to other than recipient's sex				Sex-limited service	A4	Deny
0107-F2	Claim for diagnosis limited to other than recipient's sex				Sex-limited diagnosis	A4	Deny
0109	RECIPIENT AID CATEGORY	Aid category is provided by Recipient Subsystem					
0109-F1	Aid category indicates that recipient is not eligible for benefit					A4	Deny
0109-F2	Recipient has not met share of costs under spend-down; aid category indicates that eligibility based on spend-down		Medically needy			A4	Deny
0109-F3	Recipient enrolled in prepaid health plan and not eligible for fee-based service		Enrolled in PHP	Prepaid Health Plan (e.g., HMO)		A4	Return or deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0109-F4	Claim amount includes portion of patient's spend-down requirements	Depends on State's method of handling spend-down	Medically needy			A4	Prorate
0113	THIRD-PARTY LIABILITY CODE						
0113-D1	Indication of third-party coverage on file; no indication on claim; no third-party payment	Depends on state's third-party policy	Recipient has third-party coverage			G1	Deny or pay and report
0113-D2	Claim indicates third-party coverage; not consistent with code on recipient file; third-party payment indicated on claim					G1	Pay Medicaid portion
0113-D3	Claim indicates accident; third-party liability code indicates workers' compensation or accident insurance; no payment from other insurance	Depends on state's third-party policy	Recipient has WC or accident			G1	Deny or pay and follow up
0113-H1	Claim for services provided prior to death of a medically needy recipient when recipient leaves an estate capable of payment	Depends on state's policy	Medically needy			G1	Pay and report
0114	BUY-IN STATUS CODE						
0114-D1	Recipient file indicates recipient eligible for buy-in. No Medicare coverage indicated on claim; no money collected from Medicare indicated; no EOMB attached		Medicare eligible recipient			D3	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0116	RECIPIENT EXCEPTION INDICATOR						
0116-D1	Claim is for a recipient who requires manual review on date of service		Recipient on manual review			A4	Suspend for manual review
0118	MEDICARE TYPE CODE						
0118-D1	Type code indicates that reciplent has Medicare coverage; no indication on claim; no EOMB attached		Recipient has Medicare coverage			D3	Deny
0118-D2	Medicare coverage on claim does not match Medicare type code on recipient file	Claim indicates Part A coverage only	Reciplent has Part A and Part B coverage			D3	Investigate
0118-D3	Recipient eligible for Medicare; claim indicates Medicare denied service when should have paid; no EOMB attached		Medicare eligible			D3	Deny
0201	PROVIDER ID NO.						
0201-A	Provider number missing					A1	Return or deny
0201-C	Provider number not on provider file					A3	Return or deny
0201-D1	Provider on file, but not certified for type of service billed	Depends on state policy				A3	Deny
0202	PROVIDER NAME						

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0205	PROVIDER TYPE CODE	Provide type code is from Provider Subsystem					
0205-D1	Provider type is inconsistent with claim type					A3	Return or deny
0209	PROVIDER GROUP NO.						
0209-C	Provider group number on claim does not match provider file	Applicable in states where group number is included on claim		Physician group		A3	Deny
0209-D1	Provider not registered within group			Physician who is member of group		A3	Deny
0209-D2	Rendering physician ID missing when billing provider is a group			Physician group		A3	Deny
0225	PROVIDER EXCEPTION INDICATOR						
0225-C	Claim is from a provider who requires manual review on date of service			Provider on manual review		A3	Suspend for manual review
0226	PROVIDER CREDIT BALANCE AMOUNT						
0226-E1	Valid claim for a provider with a credit balance (balance due state). Medicaid payable amount is less than credit balance	Use credits or adjustment transactions to set up credit balances		Provider with credit balance owed to state		A12	Offset entire amount of claim against credit balance
0226-E2	Valid claim for a provider with a credit balance. Medicaid payable amount is more than credit balance	Use credits or adjustment transactions to set up credit balances		Provider with credit balance owed to state		A12	Offset part of claim against credit balance Pay remainder to provider

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0233	PROVIDER-SPECIFIC RATE						
0233-H1	Claim for a provider using a rate other than the provider-specific rate for the service rendered	Depends on state policy, specifically the lower of billed vs. allowed charges		Provider-specific rate		A6	Pay lower of provider-specific rate
0234	PERCENT OF CHARGES FACTOR						
0234-D1	Claim for a provider reimbursed on a percent-of-charges basis	Depends on state policy		Provider type reimbursed on percent-of-charges basis		A6	Pay at correct percent of billed charges
0235	RATE EFFECTIVE DATE						
0235-H1	Claims for services prior to, including, and subsequent to, rate effective date			Provider-specific rate		A6	Pay or deny as appropriate
0238	PROVIDER ENROLLMENT STATUS CODE						
0238-H1	Claim is received from a provider who is ineligible to receive payment			Enrollment terminated		A3	Return or deny
0300	TRANSACTION CONTROL NO.						
0300-A	Transaction control number is missing					A1, A2	Correct
0300-B	Transaction control number is not in proper format					A1, A2	Correct

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0300-C	Transaction control number is not valid					A2	Correct
0300-G	The same transaction control number is repeated on multiple claims					A2	Correct
0301	CATEGORY OF SERVICE						
0301-C1	The category of service is not able to be determined from the data submitted on the claim					A9	Deny or return
0301-C2	The category of service is not valid for provider type					A9	Correct or return
0301-D	The category of service is inappropriate for submitted diagnosis					A5	Correct or return
0303	ATTENDING PHYSICIAN NO.						
0303-A	Attending physician number is missing			Hospital	Inpatient	A1	Return or deny
0303-C	Attending physician number is not on provider file			Hospital	Inpatient	A9	Pay and report
0303-D	Attending physician is inconsistent with category of service			Hospital	Inpatient/surgical	A9	Pay and report

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0304	REFERRING PHYSICIAN NO.						
0304-C	Referring physician number is not on provider file	Depends on state policy			Requires referral	A9	Return or deny
0304-D1	Referring physician number is not present on claim for which it is required	Depends on state policy			Requires referral	A1	Deny
0304-D2	Referring physician is inappropriate (e.g., dentist referral to a podiatrist)	Depends on state			Requires referral	A9	Deny
0304-D3	Physician refers recipient to self			Physician	Requires referral	A9	Deny
0305	PRESCRIBING PHYSICIAN NO.						
0305-A	Prescribing physician's identification is missing			Pharmacy		A1	Return or deny
0305-C	Prescribing physician number is not on provider file	Depends on state policy		Pharmacy		A9	Return or deny
0306	PRIMARY DIAGNOSIS CODE						
0306-A	Primary diagnosis code is missing	For claims that require diagnosis				A1	Deny
0306B	Primary diagnosis code is in improper format					A1	Deny
0306-C	Diagnosis code submitted is not valid					A1	Return or deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0306-D1	Diagnosis is incompatible with recipient's age (e.g., diagnosis is pregnancy, sex is male)	Diagnosis/sex criteria must be established in system first				A5	Deny
0306-D2	Diagnosis is incompatible with recipient's age (e.g., diagnosis is inter-menstrual bleeding, age of recipient is five years	Diagnosis/age criteria must be established in system first				A5	Deny
0306-D3	Diagnosis indicates accident; no third-party liability or collections indicated on claim	Diagnosis/accident criteria must be established in system first			Trauma procedure/ diagnosis	G1	Pay and report
0306-D4	An accident-related procedure and diagnosis are listed, but claim form does not indicate accident				Trauma procedure/ diagnosis	G1	Pay and report
0307	SECONDARY DIAGNOSIS CODE						
0307-C	Diagnosis code submitted is not valid					A1	Return or correct
0307-D1	Diagnosis is incompatible with recipient's sex (e.g., diagnosis is pregnancy; sex is male)	Same as 306-D1				A9	Return or deny
0307-D2	Diagnosis is incompatible with recipient's age (e.g., diagnosis is inter-menstrual bleeding, age of recipient is 5 years)	Same as 306-D2				A9	Return or deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0307-D3	Diagnosis indicates accident; no third-party liability or collections indicated on claim	Same as 306-D3			Trauma procedure/ diagnosis	G1	Pay and report
0307-H	Insufficient number of diagnosis codes to establish DRG	Depends on state reimbursement methodology		Hospital	Inpatient	A6	Return or deny
0310	BILLING DATE						
0310-C1	Service not billed within Federal billing time limitation (24 months)					A9	Deny
0310-C2	Service not billed within state billing limitations	Depends on state policy				A9	Deny
0310-D1	Billing date prior to service date					A5	Deny
0311	ADMISSION DATE						
0311-A	Admission date missing			Institutional	Inpatient	A1	Return or deny
0311-C	Admission date is not valid date (see standard validity date checks)			Institutional	Inpatient	A1	Return or deny
0311-D1	Admission date is outside recipient's period of eligibility		Specific eligibility period required	Institutional	Inpatient	A4	Deny
0311-D2	Admission date is outside provider's eligibility period			Specific eligibility period required	Inpatient	A3	Deny
0311-D3	Admission date is subsequent to ending date of service			Institutional	Inpatient	A5	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0311-D4	Admission date is not consistent with claim type (e.g., admission date on outpatient claim)				Outpatient	A1	Return or correct
0311-H1	Outpatient billing when recipient admitted prior to midnight of following day; same diagnosis	Depends on state policy		Hospital	Outpatient and inpatient	A6	Deny outpatient; pay inpatient
0311-H2	Outpatient billing when recipient admitted prior to midnight of following day; different diagnosis	Same as 311-H1		Hospital	Outpatient and inpatient	A6	Pay both
0312	BEGINNING DATE OF SERVICE	Applicable to all claim types					
0312-A	Beginning date of service is missing					A1	Return or deny
0312-C	Beginning date of service is not a valid date. (See standard validity date checks.)					A1	Return or deny
0312-D	Date of death for recipient is prior to beginning date of service	Depends on state policy for reporting patient data				A5	Deny
0312-D2	Beginning date of service is outside recipient's period of eligibility					A4	Deny
0312-D3	Beginning date of service is outside provider's period of eligibility					A3	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0312-F1	Beginning date of service is outside benefit period	Requires special eligibility or new program				A9	Deny
0312-H1	Recipient not on file on beginning date of service; retroactive eligibility covers service date	Depends on state's method of handling	Retroactive eligibility			A4	Pay
0312-H2	Beginning date of service is subsequent to recipient's eligibility period; continuing eligibility covers service date	Depends on state's method of handling	AFDC			A4	Pay
0312-H3	Recipient has prior period of eligibility; claim is from that period	Must be within claim filing limitation	Prior period of eligibility			A4	Pay
0313	ENDING DATE OF SERVICE						
0313-C	Ending date of service is not a valid date. (See standard validity date checks.)					A1	Deny
0313-D1	Ending date of service missing when required				Inpatient or consecutive dates	A1	Deny
0313-D2	Ending date of service is prior to beginning date of service					A1	Return or deny
	Dates of service are not consistent with recipient's eligibility period:						

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0313-H1	• All service dates prior to recipient's eligibility					A4	Deny
0313-H2	• Service dates overlap recipient's beginning eligibility date					A4	Pay where eligible; otherwise deny
0313-H3	• Service dates overlap recipient's ending eligibility date	Requires special recipient enrollment				A4	Pay where eligible; otherwise deny
0313-H4	• All service dates subsequent to recipient's eligibility	Requires special recipient enrollment				A4	Deny
	Dates of service not consistent with provider's eligibility period:						
0313-H5	• All service dates prior to provider's eligibility					A3	Deny
0313-H6	• Service dates overlap provider's beginning eligibility date					A3	Pay where eligible; otherwise deny
0313-H7	• Service dates overlap provider's ending eligibility date					A3	Pay where eligible; otherwise deny
0313-H8	• All service dates subsequent to provider's eligibility					A3	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0314	PLACE OF SERVICE						
0314-B	Place of service is not proper format					A1	Return or correct
0314-C	Place of service is outside valid range					A1	Return or correct
0314-D1	Place of service is missing where required					A1	Deny
0314-D2	Place of service is inconsistent with procedure code				Procedure code with restrictive place of service	A5	Return or correct
0315	REFILL INDICATOR						
0315-E	Claim for drug refill which is too soon for previous quantity to be consumed	Depends on system capabilities		Pharmacy	Drugs	A9	Deny or pay and report
0315-F1	Claim for drug refill which exceeds the maximum number of refills allowed	Depends on state policy		Pharmacy	Drugs	A9	Deny
0315-F2	Claim for drug refill which is beyond the refill time period allowed	Depends on state policy; may require a dummy claim to establish original prescription		Pharmacy	Drugs	A9	Deny
0316	PATIENT STATUS						
0316-A	Patient status code is missing			Institutional	Inpatient	A1	Return or deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0316-B	Patient status code is not proper format			Institutional	Inpatient	A1	Return or deny
0316-C1	Patient status code is outside range of valid values			Institutional	Inpatient	A1	Return or deny
0316-C2	Subsequent billing for a recipient for which prior billing indicated patient status of "death."	Depends on type of bill and state method of reporting death	Recipient File updated to show date of death	Institutional	Inpatient	A4	Pay prior; deny subsequent
0316-D1	Patient status code is inconsistent with discharge date (e.g., status of "still under care" and discharge date present)			Institutional	Inpatient	A1	Return or deny
0316-D2	Patient status code indicates discharged; no ending date of service			Institutional	Inpatient	A1	Return or deny
0317	DISCHARGED PATIENT'S DESTINATION *						
0317-D	Discharged patient's destination code is inconsistent with patient status code			Institutional	Inpatient	A1	Pay and report
0317-H	Discharged patient's destination indicates ICF; subsequent claim from SNF	Depends on system capabilities		Institutional	Inpatient	A8	Pay and report

* Note: DEs 317, 318, and 319 are normally a part of the SURS LTC wraparound feature rather than prepayment editing.

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0318	DESTINATION PROVIDER NUMBER *						
0318-D	Destination provider number is inconsistent with discharged patient's destination code	Depends on system capabilities		Institutional	Inpatient	A8	Return or deny
0319	PREVIOUS PROVIDER NUMBER *						
0320	PATIENT ACCOUNT NO.	Used for test control				A8	
0321	TOTAL CLAIM CHARGE						
0321-A	Total charge is missing					A1	Return or deny
0321-B	Total charge contains non-numeric characters					A1	Return or deny
0321-D1	Total charge on claim does not match sum of individual line item charges					A1	Return or deny
0321-D2	Charges on hospital bill less than days x per diem	Depends on state reimbursement methodology		Hospital	Inpatient	A7	Pay billed amount
0321-E1	Claim amount exceeds limit on fee file, and there is a partial payment by recipient or other insurance					A6	Deduct other payment from maximum limit on file (not billed amount), then pay

* Note: DEs 317, 318, and 319 are normally a part of the SURS LTC wraparound feature rather than prepayment editing.

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0321-H1	Incorrect patient contribution (including social security) is deducted on an SNF or ICF claim for a full-time resident	Depends on state system design		Nursing home		A6	Return or correct
0322	PROCEDURE CHARGE						
0322-A	Line item charge is missing					A1	Return or deny
0322-B	Line item charge is non-numeric					A1	Return or deny
0322-C1	Line item charge of $0 is submitted					A1	Pay $0
0322-D1	Nursing home claim with 15 days of SNF care and 17 days of ICF care for same recipient (32-day month)			Nursing home	SNF and ICF	A6	Reduce and pay
0322-D2	Assistance surgeon bills full surgical fee and indicates assistant status			Physician	Surgical procedure	A6	Reduce and pay
0322-D3	Ambulance claim for $80; claim indicates Medicare payment of $50		Medicare eligible	Transportation provider	Ambulance	A7	Deny
0322-E1	Assistance surgeon bills for a surgical procedure which does not warrant more than one surgeon	Depends on state policy		Physician	Surgical procedure	A7	Deny
0322-E2	Excessive ancillary charges on an inpatient claim	Depends on state policy		Hospital	Inpatient	A7	Reduce and pay

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0322-F1	Claim for special cataract lenses; recipient has Medicare coverage		Medicare eligible	Vision care	Cataract lenses	A7	Deny lenses
0322-F2	Nursing home claim which includes charges normally included in per diem rate	Depends on state claim form/reimbursement procedures		Nursing home		A6	Reduce and pay
0322-H1	Claim for procedure performed before rate change; submitted after rate change using new rate	Rate change required				A6	Pay old rate
0322-H2	Assistance surgeon bills correct percentage of his customary full surgical fee, indicates assistant status and his full fee is higher than full maximum allowable	Depends on whether state uses the percentage payment method		Physician	Surgical procedure	A6	Reduce to % of maximum allowable
0322-H3	Hospital claim has incorrect per diem charge	Pay lower of billed or allowed (depends on state policy)		Hospital	Inpatient	A6	Correct and pay
0322-H4	Recipient changes nursing home facilities; 15 days in one facility and 17 days in second			Nursing home		A7	Reduce and pay
0322-H5	Multiple surgery where charge for second procedure is less than full amount but still greater than maximum payable for multiple surgery	Depends on state policy		Physician	Surgical procedure	A7	Pay one line; reduce and pay second

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0322-H6	Multiple surgery, separate incisions, billed on same claim; both procedures billed at full individual amounts	Depends on state policy		Physician	Surgical procedure	A7	Pay secondary at lesser amount
0322-H7	Same as 311-C12 except procedures are billed on different claims	Depends on state policy		Physician	Surgical procedure	A7	Pay secondary at lesser amount
0322-H8	Transportation charge exceeds state's maximum			Transportation provider	Transportation	A7	Reduce and pay
0322-H9	Line item charge exceeds allowable amount					A7	Reduce and pay
0322-H10	Assistance surgeon bills full fee, does not indicate assistant status, and primary surgeon also bills			Physician	Surgical procedure	A6	Pay primary surgeon; reduce and pay assistant surgeon
0322-H11	Line item charge is less than fee amount allowed by schedule					A7	Pay charge
0323	DRUG CHARGE						
0323-A	Drug charge is missing on a pharmacy claim			Pharmacy		A1	Return or deny
0323-B	Drug charge is non-numeric			Pharmacy		A1	Return or deny
0323-C1	Drug charge of $0 is submitted			Pharmacy		A6	Pay $0
0323-C2	Drug charges on a SNF or ICF claim	Depends on state regulations		Nursing home		A6	Deny drug charges

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0323-F	Pharmacy claim, charge greater than monthly maximum benefit	Depends on state policy		Pharmacy		A7	Reduce and pay
0323-H1	Drug charge exceeds allowable amount			Pharmacy		A7	Reduce and pay
0323-H2	Pharmacy bills at wholesale cost which exceeds actual cost	Applicable where formulary contains actual costs		Pharmacy		A7	Reduce and pay
0323-H3	Pharmacy claim where charge exceeds price paid by public for same item	Applicable where formulary contains "market" price		Pharmacy		A7	Reduce and pay
0326	BLOOD NOT REPLACED						
0326-D	Claim for blood which exceeds the amount indicated by blood not replaced			Hospital		A6	Reduce and pay
0327	UNITS OF SERVICE						
0327-B	Units of service is non-numeric, negative, or not whole number					A1	Return or correct
0327-D1	Units of service is inconsistent with service dates					A6	Reduce and pay or deny or return
0327-D2	Units of service exceeds total days certified			Inpatient		A7	Reduce and pay or deny
0327-D3	Units of service for maintenance drugs is less than minimum days' supply	Depends on state policy		Pharmacy		A7	Return or deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0327-D4	Units of service for maintenance drugs is greater than maximum days' supply	Depends on state policy		Pharmacy		A7	Return or deny
0327-E1	Inpatient stay exceeds length-of-stay guidelines	Depends on state policy		Hospital		A7	Reduce and pay
0327-E2	Readmission to hospital within specified time period after discharge to circumvent length-of-stay guidelines			Hospital		A6	Reduce and pay
0327-F1	Units of service exceeds benefit limit	Can be used to test all benefit limitations			Service with benefit limit	A7	Reduce and pay
0327-F2	Claim exceeds benefit limit and shows third-party payment		Third-party resources		Service with benefit limit	A7, G1	Deduct TP payment from cap and pay
0328	THIRD-PARTY LIABILITY ACTION	Not used in most systems					
0329	THIRD-PARTY PAYMENT AMOUNT						
0329	Third-party payment amount, but no third-party resources		No TP resources on recipient file			G1	Pay and report
0330	MEDICARE DEDUCTIBLE AMOUNT						
0330-D1	Medicare deductible on inpatient hospital claim exceeds required amount		Medicare eligible	Hospital	Inpatient	E1	Reduce and pay

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0330-H2	Cumulative Medicare deductible for Part B services exceeds current maximum amount	Depends on system design	Medicare eligible		Part B services	E1	Pay first; reduce and pay second
0331	MEDICARE BLOOD DEDUCTIBLE						
0331-D1	Medicare blood deductible exceeds required quantity		Medicare eligible	Hospital	Inpatient	E1	Reduce and pay
0332	MEDICARE COINSURANCE AMOUNT						
0332-D1	Medicare coinsurance exceeds 20% of total physician charge		Medicare eligible	Physician		E1	Reduce and pay
0333	MEDICARE COINSURANCE DAYS						
0333-D1	Medicare coinsurance days exceed maximum allowed number of coinsurance days for a period		Medicare eligible	Hospital	Inpatient	E1	Reduce and pay
0335	ADJUSTMENT AMOUNT						
0335-H1	Adjustment or original claim results in combined charge exceeding limits on fee file	Two claims required				A12	Pay first; reduce and pay second
0340	PRIOR AUTHORIZATION CONTROL NO.						
0340-A	Claim requiring prior authorization; prior authorization control number is missing				Procedure requiring PA	A11	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0340-C	Prior authorization number is not valid	Depends on state coding system			Service requiring PA	All	Return
0340-G1	Two claims from different hospitals with same prior authorization number, same dates of service, same recipient, and same services					All	Investigate
	Claim is inconsistent with prior authorization:					All	
0340-H1	• Recipient ID does not match						Deny
0340-H2	• Provider ID does not match						Deny
0340-H3	• Procedure code does not match						Deny
0340-H4	• Dates of service do not match authorization dates or authorization has expired						Deny
0340-H5	• Claim amount exceeds authorized amount						Reduce and pay
0340-H6	Authorized amount exceeds amount in fee schedule	Depends on state policy				All	Pay authorized amount
0340-H7	Claim for usually non-covered service; P.A. attached	Depends on state policy			Non-covered service	All	Pay

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0378	DATE OF SURGERY						
0378-C1	Date of surgery not valid (see standard validity date checks)					A1	Return or deny
0378-D1	No date of surgery; procedure indicates surgery was performed					A5	Return or deny
0378-D2	Date of surgery indicated, but no surgical procedure included					A5	Return or deny
0378-E1	Excess time between date of surgery and admission date	Depends on state policy				A5	Pay and report
0379	LEAVE DAYS						
0379-F1	Leave days exceed maximum number allowed. Could include therapeutic leave or hospitalization or both	Applicable to states which allow reimbursement for leave days		Nursing home		A9	Reduce and pay
0380	ALLOWABLE PROCEDURE AMOUNT						
0380-H1	Amount billed is less than all other pricing amounts					A7	Pay amount billed
0380-H2	Fee schedule is less than amount billed, UCR amount, and area prevailing	Depends on state reimbursement policy				A7	Pay fee schedule amount
0380-H3	Usual, customary, and reasonable charge is less than amount billed, fee schedule, and area prevailing	Depends on state reimbursement policy				A7	Pay UCR amount

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0380-H4	Area prevailing charge is less than amount billed, UCR amount, and fee schedule	Depends on state reimbursement policy				A7	Pay area prevailing amount
0381	PROFESSIONAL FEE/ DISPENSING FEE						
0381-H1	Professional fee billed exceeds the allowable amount	Depends on system design		Pharmacy		A6	Reduce and pay
0384	TYPE OF SERVICE						
0384-C1	Type of service not valid					A1	Deny
0384-D1	Procedure code - type of service inconsistent					A6	Correct or deny
0386	PRESCRIPTION NO.	Used for test control					
0386-A	Prescription number missing			Pharmacy		A1	Return
0388	SCREENING RESULTS CODE						
0388-A	Screening results code missing (incomplete EPSDT screen)		EPSDT eligible	EPSDT screening provider	EPSDT screening service	D1	Return or deny
0388-B	Screening code is inappropriate format	Depends on state claim form	EPSDT eligible	EPSDT screening provider	EPSDT screening service	D1	Return or correct
0388-C	Claim for EPSDT-covered services; prior screening claim not submitted	Depends on state claim form	EPSDT eligible	EPSDT screening provider	EPSDT screening service	D1	Deny
0388-D	Abnormality found during EPSDT screen; no referral indicated	Depends on state claim form	EPSDT eligible	EPSDT screening provider	EPSDT screening service	D1	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0389	SCREENING REFERRAL CODE						
0389-C	Referral code is not valid	Depends on state claim form	EPSDT eligible	EPSDT screening provider	EPSDT screening service	D1	Correct or deny
0389-D	Code is not consistent with screening results code	Depends on state claim form	EPSDT eligible	EPSDT screening provider	EPSDT screening service	D1	Correct or deny
0390	EPSDT INDICATOR						
0390-D1	Claim for recipient not under 21 years of age			EPSDT screening provider	EPSDT screening service	D1	Deny
0390-D2	Claim with screening procedure code and no EPSDT indicator	Not applicable to state that uses screening forms as invoice	EPSDT eligible	EPSDT screening provider	EPSDT screening service	D1	Deny
0391	FAMILY PLANNING CODE						
0391-D1	Family planning code is inconsistent with procedure				Family planning procedure	D2	Deny
0391-D2	Family planning code is inconsistent with provider type	Depends on state policy		Provider not eligible to provide family planning	Family planning service	D2	Deny
0391-D3	Family planning code present; service not family planning				Non-family planning service	D2	Pay; not coded for FP
0392	MEDICAID DEDUCTIBLE AMOUNT						
0392-F	Claim for service that requires a deductible; no indication that deductible was taken	Depends on state policy			Service eligible for deductible	A7	Reduce and pay correct amount

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0393	MEDICAID COPAYMENT AMOUNT						
0393-A	Medicaid copayment is excluded on claim	Applicable in states which require Medicaid copayment			Service eligible for copay	A1	Reduce and pay
0393-C1	Copayment is incorrect	Applicable in states which require Medicaid copayment			Service eligible for copay	A7	Return
0393-C2	Provider increases fee to compensate for copayment	Applicable in states which require Medicaid copayment			Service eligible for copay	A6	Reduce and pay maximum less copayment amount
0397	OPERATING PHYSICIAN NO.						
0397-B	Operating physician number is inappropriate format			Hospital	Inpatient	A1	Return
0397-C	Operating physician is ineligible to participate in the Medicaid program			Ineligible provider	Surgical procedure	A3	Pay and report
0397-D1	Procedure indicates surgery, operating physician number missing				Surgical procedure	A6	Return or deny
0397-H1	Provider type is inappropriate for type of surgery performed	Depends on state policy			Surgical procedure	A3	Pay and report
0399	CERTIFICATION STATUS						
0399-A	Certification status missing on institutional claim	Recipient in institution		Institution		A1	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0400	CERTIFICATION/RECERTIFICATION DATE						
0400-A	Certification/recertification date missing on institutional claim	Recipient in institution		Institution		A1	Deny
0400-C	Certification/recertification date invalid (standard format and validity date checks)			Institution		A1	Return
0400-DI	Certification/recertification date is prior to date of admission			Institution		A5	Return or correct
0400-HI	Certification/recertification date is outside period of recipient eligibility			Institution		A4	Deny
0403	TOTAL DAYS CERTIFIED						
0403-D	Length of stay exceeds total days certified			Institution		A7	Reduce and pay
0403-E	Total days certified exceeds LOS parameters			Institution		A7	Reduce and pay
0408	STATE MEDICAL ASSISTANCE REVIEW ACTION						
0417	DATE OF CONSENT FOR STERILIZATION						
0417-A	Consent date is missing	Depends on system design			Sterilization	A1	Deny
0420	DATE OF ONSET	Not used in most systems					

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0421	EMERGENCY INDICATOR						
0421-D	Claim with emergency indicated on form	Depends on state TPL policy				G1	Pay and report
0422	ACCIDENT INDICATOR						
0422-D	Claim with accident indicated on form	Depends on state TPL policy				G1	Pay and report
0423	EMPLOYMENT RELATED INDICATOR						
0423-D	Claim with employment related accident indicated on form	Depends on state TPL policy				G1	Deny and report
0430	DAY'S SUPPLY OF DRUG						
0430-A	Claim with day's supply missing			Pharmacy		A6	Deny
0430-H	Claim with day's supply less than minimum indicated on drug file	Depends on state policy and system features		Pharmacy		A6	Pay and investigate
0430-12	Second claim for same recipient within normal day's supply period	Depends on state policy and system features		Pharmacy		A6	Deny or pay and investigate
0500	PROCEDURE CODE						
0500-A	Procedure code missing					A1	Return or deny
0500-B	Procedure code is inappropriate format					A1	Return or deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0500-C1	Claim with invalid procedure code					A1	Return or deny
0500-C2	Improper use of procedure modifier code which results in overbilling				Service which allows modifier	A6	Reduce and pay
0500-C3	Claim in which time units are automatically added to base units	Only applies in states which use base plus time		Anesthesiologist or Psychiatrist	Anesthesia or psychiatric	A1	Reduce and pay
	Procedure code is inconsistent with:						
0500-D1	• Recipient age					A5	Deny
0500-D2	• Recipient sex					A5	Deny
0500-D3	• Provider type					A5	Deny
0500-D4	• Place of service					A5	Deny
0500-D5	• Past procedure					A5	Deny 2nd claim
0500-D6	• Diagnosis					A5	Return or deny
0500-D7	• Provider specialty					A5	Deny
0500-E	Claim for several single lab procedures which should be billed as one inclusive laboratory panel			Laboratory		A5	Deny
0500-F1	Claim for cosmetic surgery (e.g., mammoplasty augmentation); prior authorization				Cosmetic surgery	A11	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0500-F2	Claim for non-covered service				Non-covered service	A6	Deny
0500-F3	Claim for broken appointment	Procedure is described as broken appointment				A6	Deny
0500-F4	Claim for medical procedures considered experimental or not generally employed by medical profession				Experimental procedures	A6	Deny
0500-F5	Claim for house call	Depends on state policy				A6	Deny or pay
	Claims for any of the following services more than once within a specified time period:	Applicable to states with a dental program; depends on state benefit limitations		Dentist	Dental service	A6	Pay first; deny second
0500-F6	• Initial exam						
0500-F7	• Periodic oral exam						
0500-F8	• Prophylaxis						
0500-F9	• Topical fluoride application						
0500-F10	• Diagnostic X-rays						
0500-F11	• Full series X-rays						
0500-F12	• Restorative work on same tooth service						
0500-F13	• Patient education						
0500-F14	• Dentures						

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
	Claims for services of other provider types more than allowed within a specified time frame:	Depends on state policy other benefit limitation tests can added				A6	Pay first; deny second
0500-F15	• Second screening service						
0500-F16	• Routine eye exam						
0500-F17	• Change of glasses						
0500-F18	• Second consultation						
0500-F19	• Second initial office visit						
0500-F20	• Hearing examination						
0500-F21	Claim for luxury items included in "other ancillary"			Institution		A6	Deny luxury item
0500-F22	Claim for service which is rendered free to general public (e.g., immunization)					A6	Deny
0500-F23	Claim for two-way emergency transportation					A6	Reduce and pay
0500-G1	Identical duplicate claims received in separate cycles	Could be multiple tests (e.g., first claim in prior cycle, first claim in current cycle - 5, first claim in current cycle - 10, etc.)				B3	Deny second
0500-G2	Identical duplicate claims received in same cycle					B3	Deny duplicate

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0500-G3	Identical duplicate lines on a claim					B3	Deny duplicate line
0500-G4	Identical duplicate claims, first claim suspended					B3	Pay one, deny other
0500-G5	Duplicate claim except with different, but comparable, procedure					B3	Suspend and review
0500-G6	Single claim has lines with different but comparable procedures					B3	Suspend and review
0500-G7	Duplicate claim except with date of service different but in close proximity					B3	Suspend and review
0500-G8	Duplicate claim, except with a different provider, received after paying first claim					B3	Suspend and review
0500-G9	Duplicate claim except provider is the group practice of the original provider					B3	Deny second
0500-G10	Duplicate claim except charge is higher					B3	Deny second
0500-G11	Duplicate claim except charge is lower					B3	Pay first; pay second and recover first
	Duplicate claims submitted by different provider service types:					B3	Deny second

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0500-G12	• Hospital-based physician bills through hospital and own provider number						
0500-G13	• Physician and laboratory bill for lab tests						
0500-G14	• Physician and radiologist bill for X-ray						
0500-G15	• Inpatient stays for same patient during same period by hospital and nursing home						
0500-G16	Provider submits duplicate claims using different provider numbers	Applicable in states which allow multiple provider numbers				B3	Deny second
0500-G17	Duplicate claims by rural health clinic and by physician					B3	Deny physician claim
0500-G18	Identical duplicate submitted after recipient has received a change in ID	Applicable in states where Medicaid ID number can change				B3	Deny second
	Second claim has procedure incompatible with procedure on a previous claim; same provider						
0500-H1	• Dental claim for tooth filling subsequent to claim for extraction of same tooth			Dentist	Dental	A6	Deny second claim

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0500-H2	• Physician claim for unilateral mastectomy subsequent to claim for bilateral mastectomy			Physician		A6	Deny second claim
0500-H3	• Dental claims for tooth extraction subsequent to claim for extraction of same tooth			Dentist	Dental	A6	Deny second claim
0500-H4	• Physician claim for finger amputation subsequent to claim for amputation of same arm			Physician		A6	Deny second claim
0500-H5	Second claim has procedure incompatible with procedure on previous claim; different providers					A6	Suspend and review
0500-H6	Claims for prenatal care and total maternity care; same provider					A6	Deny prenatal care
0500-H7	Hospital visit billed on same day as surgery by same physician					A6	Deny visit
0500-H8	Multiple maternity claims for same recipient: • Physician claim - prenatal • Rural health claim - prenatal • Outpatient claim - prenatal • Inpatient claim - delivery • Physician claim - total care					A6	Pay inpatient and total care; suspend and review others

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0500-H9	Claims for visits to three different providers on same day, no referrals	"Doctor-shopping"				A6	Investigate
0500-H10	Claim for "consultation" after previous claim indicated that physician had "assumed care" with an initial office visit; claims in same cycles					A6	Pay first; return or reduce second
0500-H11	Four claims for different procedures that are improbable on the same day for the same recipient (e.g., four different diagnoses — cold, ascites, congestive heart failure, and false labor); two claims in one cycle; two in the next					A6	Suspend and review
0500-H12	Procedures incidental to major surgery (e.g., biopsy, endoscopy, more than one procedure in an incision) performed by same physician					A6	Reduce and pay
0500-H13	Concurrent hospital care for same recipient by different providers. One claim for initial visit and follow-ups; second claim for consultation and follow-ups over same period. Claims in same cycle					A6	Suspend and review

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0500-H14	Claims for major surgery and associated post-operative care, performed by same physician; post-care occurs during follow-up period. Claims in different cycles					A6	Deny second
0500-H15	Physician claim for hospital visit during portion of a hospital stay which was previously disallowed or reduced					A6	Deny
0500-H16	Two claims for once-in-a-lifetime procedure				Once per lifetime procedure	A6	Pay first; deny second
0501	DRUG CODE						
0501-A	Drug code is missing			Pharmacy		A1	Return or deny
0501-B	Drug code is inappropriate format			Pharmacy		A1	Return or deny
0501-C	Drug code is invalid			Pharmacy		A1	Return or deny
	Drug is inconsistent with:						
0501-D1	• Recipient age			Pharmacy		A5	Deny
0501-D2	• Recipient sex			Pharmacy		A5	Deny
0501-F1	Claim for over-the-counter drugs	Applicable to states which restrict reimbursement for OTC drugs		Pharmacy		A6	Deny
0501-F2	Claim for specifically non-covered prescription drugs	Depends on state policy		Pharmacy		A6	Deny

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
0501-F3	Claim for brand name when state requires generic	Depends on state policy		Pharmacy		A6	Deny
0501-G1	Claims for same drug for same reciplent on same day	Depends on state policy		Pharmacy		B3	Deny second
0501-G2	Refill dispensed with less than original prescribed quantity with full professional fee			Pharmacy		B3	Reduce and pay
0513	DRUG UNIT OF MEASURE						
01545	NURSING HOME LEVEL OF CARE CODE						
01545-H1	Claim with level of care different than shown on recipient file	Depends on state policy and system features	NH recipient	Long term care provider		A6	Correct and pay
01545-H2	Claim with level of care not authorized for provider	Depends on state policy and system features	NH recipient	Long term care provider		A6	Correct and pay
01546	PATIENT LIABILITY AMOUNT						
01546-I1	Claim with patient liabillty less than amount on state file		NH recipient	Long term care provider		A6	Pay and report
01546-J1	Claim with correct patient liability amount	Pricing test	NH recipient	Long term care provider		A6	Pay correct amount

Situation No.	Claim Situations	Comments	Recipient Characteristics	Provider Characteristics	Service Characteristics	F&F	Expected Disposition
	Standard Validity Date Checks:						
	a. Value of month is outside range of 1-12						
	b. Value of day is outside range of 1-31,						
	c. Value of date is greater than current date						
	d. Date contains non-numeric characters						
	e. Value of day is invalid for given month (i.e, June 31)						

CHAPTER IV
TEST RECIPIENTS

The set of test recipients is provided in the following lists. Separate sets of recipients are provided for:

- Base test
- State-unique programs
- Nursing home residents
- HMO enrollees
- Special program enrollees

The defined characteristics for each recipient are:

- Sequence number
- Name
- Social Security number
- Sex
- Relation to case head
- Medicare coverage
- Date of birth
- Third-party resources
- Basis of eligibility

The codes used to identify these characteristics are:

Medicare Coverage

1 Non-Medicare
2 Part A and Part B
3 Part B Only
4 Part A Only

Third-Party Resources

A None
B Private Insurance
C Workers' Compensation
D CHAMPUS

E HMO
F Other

Program

AFDC-CN	Aid to Families With Dependent Children - Categorically Needy
SSI	Supplemental Security Income
AFDC-MN	Aid to Families With Dependent Children - Medically Needy
AFDC-FC	Foster Care Children
MR	Mental Retardation

Medicare SSN Suffixes

A	Wage Earner
B	Female Using Husband's Number
D	Widow Using Husband's Number
B1	Husband Using Wife's Number
B2	Young Wife With Qualifying Child
C1	Children, Either Sex

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B1	Abele, Lillian E.	812-01-7050	F	Case Head	1	04/07/-43	A	AFDC-CN	Enroll after -30, enroll in PHP at +60
B2	Abele, John B.	613-03-0736	M	Dep Child	1	09/12/-16	A	AFDC-CN	
B3	Abney, Charles H.	984-06-0445A	M	Case Head	2	11/08/-70	A	SSI	
B4	Akins, Rose C.	613-05-4488	F	Case Head	1	06/05/-21	A	AFDC-CN	
B5	Akins, James C.	621-07-5553	M	Dep Child	1	01/04/-02	A	AFDC-CN	
B6	Allen, Pearlie J.	831-094900	F	Case Head	1	08/07/-40	B	AFDC-MN	
B7	Allen, Paul D.	633-02-1035	M	Dep Child	1	03/21/-14	B	AFDC-MN	
B8	Ancheta, Susan H.	824-04-2836	F	Case Head	1	09/26/-29	A	AFDC-CN	
B9	Ancheta, Nick D.	606-06-8966	M	Dep Child	1	07/13/-10	A	AFDC-CN	
B10	Andrews, Andrea M.	818-08-7323	F	Case Head	1	02/18/-33	A	AFDC-CN	
B11	Andrews, Lois A.	639-10-7210	F	Dep Child	1	07/15/-13	A	AFDC-CN	
B12	Austing, Sharon R.	965-08-2819B	F	Case Head	2	07/21/-69	A	SSI	
B13	Backman, Carrie R.	811-01-7798	F	Case Head	1	03/13/-35	A	AFDC-CN	
B14	Backman, Donad E.	670-03-8662	M	Dep Child	1	11/07/-14	A	AFDC-CN	
B15	Barringer, Irene L.	858-05-1194	F	Case Head	1	09/21/-37	A	AFDC-CN	
B16	Barringer, Pete G.	660-07-1338	M	Dep Child	1	02/05/-18	A	AFDC-CN	
B17	Bellessa, Cheryl L.	833-09-4782	F	Case Head	1	12/17/-24	A	AFDC-CN	
B18	Bellessa, Kay M.	694-02-4498	F	Dep Child	1	06/24/-05	A	AFDC-CN	
B19	Bishop, Joan L.	878-04-4621	F	Case Head	1	04/03/-32	A	AFDC-CN	

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B20	Bishop, Roger C.	637-06-5761	M	Dep Child	1	10/14/-11	A	AFDC-CN	
B21	Biwer, Bengamin M.	942-10-3740A	M	Case Head	3	12/16/-68	B	SSI	
B22	Borrero, Maria R.	898-08-0267	F	Case Head	1	05/23/-28	A	AFDC- CN	
B23	Borrero, Louise P.	606-10-6574	F	Dep Child	1	10/12/-04	A	AFDC-CN	
B24	Brewer, Evelyn L.	973-01-9610B	F	Case Head	2	12/17/-67	A	SSI	
B25	Browne, Bernice A.	936-02-1321B	F	Case Head	2	02/06/-66	A	SSI	
B26	Buford, Cynthia R.	827-03-3798	F	Case Head	1	02/27/-35	A	AFDC-CN	
B27	Buford, Jerry D.	663-05-9922	M	Dep Child	1	08/14/-08	A	AFDC-CN	
B28	Burford, Thelma N.	606-07-4326	F	Dep Child	1	12/02/-17	A	AFDC-CN	
B29	Caldwell, Leona E.	879-09-0614	F	Case Head	1	05/11/-29	A	AFDC-CN	
B30	Caldwell, Jack C.	615-02-3003	M	Dep Child	1	03/23/-09	A	AFDC-CN	
B31	Caleen, Connie J.	913-01-7156B	F	Case Head	4	03/05/-65	A	SSI	
B32	Chivers, Myrtle K.	833-04-8005	F	Case Head	1	02/19/-37	B	AFDC-MN	
B33	Chivers, Edward S.	617-06-8356	M	Dep Child	1	09/15/-17	B	AFDC-MN	
B34	Collins, Mary J.	842-08-9873A	F	Case Head	3	01/21/-62	A	SSI	
B35	Cole, Gene R.	922-04-8561A	M	Case Head	2	04/11/-67	A	SSI	
B36	Cooper, Coris D.	976-03-8470D	F	Case Head	2	05/13/-66	A	SSI	Change ID +25
B37	Croissant, Ellen J.	813-10-8244	F	Case Head	1	11/02/-33	A	AFDC-CN	
B38	Croissant, Barbara K.	657-01-5448	F	Dep Child	1	10/07/-10	A	AFDC-CN	

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B39	Dahner, Martha T.	945-05-7935D	F	Case Head	2	08/16/-72	B	SSI	
B40	Davis, Suzanne R.	840-03-7212	F	Case Head	1	07/06/-34	A	AFDC-CN	
B41	Davis, Patty B.	644-05-8650	F	Dep Child	1	04/27/-15	A	AFDC-CN	
B42	Dontos, Rosemary D.	855-07-8927	F	Case Head	1	03/23/-37	A	AFDC-CN	
B43	Dontos, Larry A.	635-09-8623	M	Dep Child	1	11/26/-11	A	AFDC-CN	
B44	Duran, Virginia E.	813-02-3173	F	Case Head	1	09/17/-24	A	AFDC-CN	
B45	Duran, Bill T.	607-04-9712	M	Dep Child	1	07/04/-05	A	AFDC-CN	
B46	Edrada, Leola B.	804-06-4372	F	Case Head	1	04/13/-25	A	AFDC-CN	
B47	Edrada, Linda C.	691-08-7480	F	Dep Child	1	08/21/-06	A	AFDC-CN	
B48	Elmer, Charles D.	906-07-0955	M	Case Head	1	09/09/-67	A	SSI	
B49	Escarez, Anita N.	867-10-1783	F	Case Head	1	09/22/-37	B	AFDC-CN	
B50	Escarez, Eddie J.	616-01-4542	M	Dep Child	1	11/02/-11	A	AFDC-CN	
B51	Escarez, Debbie L.	672-03-8180	F	Dep Child	1	03/28/-14	A	AFDC-CN	
B52	Fischer, Joan L.	921-05-5124B	F	Case Head	2	07/14/-67	A	SSI	
B53	Fontaine, Margaret	923-09-1066A	F	Case Head	4	04/22/-66	A	SSI	
B54	Fraher, Michael A.	905-07-5691A	M	Case Head	2	07/20/-68	A	SSI	
B55	Fuentes, Gloria G.	834-09-5776	F	Case Head	1	04/26/-28	A	AFDC-CN	
B56	Fuentes, Jose M.	677-02-3783	M	Dep Child	1	07/05/-09	A	AFDC-CN	
B57	Gilligan, Vera H.	981-04-4460	F	Case Head	1	10/25/-42	C	AFDC-CN	

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B58	Gilligan, Gary B.	693-06-8391	M	Dep Child	1	11/26/-14	A	AFDC-CN	
B59	Gonzalez, Godfrey J.	989-02-5014B1	M	Case Head	3	10/19/-68	A	SSI	
B60	Graham, Betty S.	868-08-8973	F	Case Head	1	11/21/-30	A	AFDC-CN	
B61	Graham, Ben F.	629-10-9024	M	Dep Child	1	07/21/-10	A	AFDC-CN	
B62	Haggard, Ramona T.	894-01-1248	F	Case Head	1	06/16/-35	A	AFDC-CN	
B63	Haggard, Richard L.	619-03-8299	M	Dep Child	1	07/13/-15	A	AFDC-CN	
B64	Harden, Clayton A.	971-04-2530A	M	Case Head	2	03/24/-69	A	SSI	
B65	Himelhoch, Nellie B.	825-05-7170	F	Case Head	1	06/04/-37	A	AFDC-MN	
B66	Himelhoch, Joe H.	676-07-2672	M	Dep Child	1	05/17/-17	A	AFDC-MN	
B67	Hobbs, Linda T.	911-06-1596A	F	Case Head	2	06/07/-67	A	SSI	
B68	Imeson, Shirley S.	812-09-6403	F	Case Head	1	04/08/-27	A	AFDC-CN	
B69	Imeson, George W.	619-02-7892	M	Dep Child	1	12/21/-17	A	AFDC-CN	
B70	Jacobs, Jerome T..	968-08-2583A	M	Case Head	3	01/29/-68	B	SSI	
B71	Johnson, Margaret A.	853-04-8554	F	Case Head	1	11/27/-40	A	AFDC-CN	
B72	Johnson, Lee F.	616-06-5234	F	Dep Child	1	10/20/-04	A	AFDC-CN	
B73	Kendrick, Irene C.	895-08-0001	F	Case Head	1	07/26/-27	A	AFDC-CN	
B74	Kendrick, Anita A.	625-10-9530	F	Dep Child	1	01/14/-05	A	AFDC-CN	
B75	Kim, Ryan A.	922-10-2967	M	Case Head	1	02/01/-66	A	SSI	
B76	Lambert, Cecelia M.	864-01-1726	F	Case Head	1	02/22/-38	B	AFDC-CN	

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B77	Lambert, Daniel R.	634-03-0872	M	Dep Child	1	07/23/-18	B	AFDC-CN	
B78	Lambert, Janice N.	615-05-2194	F	Dep Child	1	08/18/-19	B	AFDC-CN	
B79	Levenson, Connie B.	937-01-8753D	F	Case Head	2	05/12/-67	A	SSI	
B80	Lopez, Carmen D.	833-07-6598	F	Case Head	1	10/04/-35	A	AFDC-CN	
B81	Lopez, Alfredo R.	684-09-5824	M	Dep Child	1	11/26/-09	A	AFDC-CN	
B82	Marshall, Joanne E.	836-02-4746	F	Case Head	1	07/28/-28	A	AFDC-CN	
B84	Marston, Janet C.	954-03-1164B	F	Case Head	2	07/11/-70	A	SSI	
B85	Mendoza, Mary R.	816-06-6370	F	Case Head	1	11/16/-23	A	AFDC-CN	
B86	Mendoza, Juan G.	649-08-8658	M	Dep Child	1	10/18/-04	A	AFDC-CN	
B87	Mordics, Michael P.	983-05-4200A	M	Case Head	4	09/27/-71	B	SSI	
B88	Morgan, Doris J.	868-10-3702	F	Case Head	1	07/21/-31	A	AFDC-CN	
B89	Morgan, John H.	641-01-3276	M	Dep Child	1	05/11/-08	A	AFDC-CN	
B90	Norris, Ida Mae	857-03-2816	F	Case Head	1	05/01/-27	A	AFDC-MN	Cancel effective +90
B91	Norris, Philips S.	678-05-6222	M	Dep Child	1	04/18/-06	A	AFDC-MN	
B92	Nugent, Robin B.	979-07-7489D	F	Case Head	2	11/08/-66	A	SSI	
B93	Odem, Susan K.	918-09-5257D	F	Case Head	2	03/17/-68	A	SSI	
B94	Ortiz, Juanita M.	815-07-6388	F	Case Head	1	11/12/-22	A	AFDC-CN	
B95	Ortiz, Richard P.	652-09-5277	M	Depe Child	1	04/25/-04	A	AFDC-CN	
B96	Peterson, Marilyn A.	813-02-0125	F	Case Head	1	02/14/-38	B	AFDC-CN	

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B97	Peterson, Sheila L.	653-04-1782	F	Dep Child	1	01/29/-18	A	AFDC-CN	
B98	Pierce, Judith R.	849-06-7019	F	Case Head	1	11/23/-28	A	AFDC-CN	
B99	Pierce, Dorothy B.	608-08-0445	F	Dep Child	1	07/23/-05	A	AFDC-CN	
B100	Posner, Elena S.	949-02-6926B	F	Case Head	2	06/22/-67	A	SSI	
B101	Pritchard, Janet D.	640-10-5086	F	Case Head	1	12/09/-35	A	AFDC-CN	
B102	Pritchard, James J.	645-01-3581	M	Dep Child	1	11/09/-18	A	AFDC-CN	
B103	Reynolds, Kathleen A.	839-03-3802	F	Case Head	1	06/21/-33	A	AFDC-CN	
B104	Reynolds, Jerry E.	610-05-8806	M	Dep Child	1	01/12/-17	A	AFDC-CN	
B105	Ridsdale, Cleveland B.	955-04-5672A	M	Case Head	3	10/09/-67	A	SSI	
B106	Rodriquez, Maria M.	826-07-0110	F	Case Head	1	08/13/-26	A	AFDC-MN	
B107	Rodriquez, Luis G.	687-09-9944	M	Dep Child	1	07/21/-04	A	AFDC-MN	
B108	Romero, Karla S.	838-02-3904	F	Case Head	1	08/26/-29	B	AFDC-CN	
B109	Romero, Jeffrey F.	637-04-5214	M	Dep Child	1	10/11/-10	B	AFDC-CN	Prior eligibility to -120
B110	Sanchez, Susan L.	859-06-3787	F	Case Head	1	07/24/-39	A	AFDC-CN	
B111	Sanchez, Mary K.	683-08-4653	F	Dep Child	1	03/17/-18	A	AFDC-CN	
B112	Sanders, Dixie H.	909-06-3682B	F	Case Head	4	05/18/-75	A	SSI	
B113	Santarone, Barbara S.	947-08-3274D	F	Case Head	2	09/16/-78	A	SSI	Died +30
B114	Seibert, Ellen C.	839-10-2944	F	Case Head	1	02/26/-38	A	AFDC-MN	
B115	Seibert, David D.	616-01-4369	M	Dep Child	1	07/25/-19	A	AFDC-MN	

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B116	Shibata, Rose I.	886-03-6188	F	Case Head	1	11/07/-35	A	AFDC-CN	
B117	Shibata, Tom H.	691-05-8889	M	Dep Child	1	06/27/-09	A	AFDC-CN	
B118	Singer, Johnnie N.	928-10-1324A	M	Case Head	2	04/12/-73	A	SSI	
B119	Smith, Theresa B.	890-07-2868	F	Case Head	1	07/16/-39	A	AFDC-CN	
B120	Smith, William O.	698-09-4015	M	Dep Child	1	03/19/-18	A	AFDC-CN	
B121	Sorenson, Myrtle M.	886-02-1991	F	Case Head	1	05/18/-56	C	AFDC-CN	
B122	Sorenson, Agnes T.	648-04-9846	F	Dep Child	1	06/16/-19	A	AFDC-CN	
B123	Stevens, Joyce B.	801-06-5875	F	Case Head	1	07/13/-32	A	AFDC-CN	
B124	Stevens, Fred H.	632-08-7175	M	Dep Child	1	05/12/-18	A	AFDC-CN	
B125	Stewart, Donald R.		M	Dep Child		08/30/-12			
B126	Suarez, Maureen C.	861-10-7047	F	Case Head	1	09/27/-31	A	AFDC-CN	
B127	Suarez, Gilberto T.	671-01-7998	M	Dep Child	1	10/12/-10	A	AFDC-CN	
B128	Talbot, Kenneth R.	969-01-6922A	M	Case Head	2	07/24/-68	A	SSI	
B129	Taylor, Barbara L.	826-03-9427	F	Case Head	1	11/27/-27	A	AFDC-CN	
B130	Taylor, Charles P.	642-05-2520	M	Dep Child	1	12/23/-03	A	AFDC-CN	
B131	Thomas, Alex H.		M	Dep Child		04/27/-15		AFDC-FC	Enroll effective +6; has retroactive eligibility
B132	Thornton, Nancy B.	803-07-7886	F	Case Head	1	06/29/-38	A	AFDC-CN	
B133	Thornton, Debbie K.	658-09-6836	F	Dep Child	1	02/07/-17	A	AFDC-CN	
B134	Thornton, Joan S.	621-02-5483	F	Dep Child	1	04/16/-15	A	AFDC-CN	

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B135	Tordillos, Maria A.	844-04-9401	F	Case Head	1	05/12/-35	A	AFDC-CN	
B136	Tordillos, Luciana R.	666-06-5250	F	Dep Child	1	06/16/-16	A	AFDC-CN	Cancel effective +60: has continuing eligibility
B137	Torres, Roberta C.	877-08-8854	F	Case Head	1	08/14/-35	B	AFDC-CN	
B138	Torres, Samuel J.	606-10-6351	M	Dep Child	1	04/02/-12	A	AFDC-CN	
B139	Turner, Linda M.	893-01-4320	F	Case Head	1	12/09/-36	A	AFDC-MN	Cancel effective +90
B140	Turner, Betty Jo	674-03-0359	F	Dep Child	1	11/07/-14	A	AFDC-MN	
B141	Unseth, Karen N.	870-05-7635	F	Case Head	1	10/09/-31	A	AFDC-CN	
B142	Unseth, Malcolm R.	696-07-0376	M	Dep Child	1	08/15/-06	A	AFDC-CN	
B143	Valdez, Rosario A.	838-09-8787	F	Case Head	1	06/14/-35	A	AFDC-CN	
B144	Valdez, Jean S.	668-02-2772	F	Dep Child	1	05/13/-06	A	AFDC-CN	
B145	Valiton, Bonnie R.	828-04-4665	F	Case Head	1	05/11/-32	B	AFDC-CN	
B146	Valiton, David A.	649-06-5499	M	Dep Child	1	2//28/-12	B	AFDC-CN	
B147	Valliere, Dick J.	975-03-2503B1	M	Case Head	2	03/25/-67	A	SSI	Enroll effective -30, died +46
B148	Vogel, Marcia C.	897-08-9406	F	Case Head	1	07/11/-24	A	AFDC-CN	
B149	Vogel, Leonard T.	675-10-1743	M	Dep Child	1	01/18/-06	A	AFDC-CN	
B150	Walker, Laura J.	826-01-0264	F	Case Head	1	02/26/-34	A	AFDC-CN	
B151	Walker, Michelle K.	664-03-5549	F	Dep Child	1	08/23/-07	A	AFDC-CN	
B152	Washington, Earl J.	929-05-9543A	M	Case Head	3	02/27/-76	A	SSI	Died +30
B153	Watson, Frances D.	823-05-3125	F	Case Head	1	07/11/-39	A	AFDC-CN	

RECIPIENT PROFILES
BASE DATA

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
B154	Watson, Robert T.	611-07-9202	M	Dep Child	1	01/28/-18	A	AFDC-CN	
B155	Webster, Denise C.	801-09-9869	F	Case Head	1	11/20/-34	B	AFDC-CN	
B156	Webster, Edwin E.	602-02-9684	M	Dep Child	1	11/10/-08	A	AFDC-CN	
B157	Webster, Judy M.	618-04-3672	F	Dep Child	1	02/12/-17	A	AFDC-CN	
B158	Wheeler, Annie F.	943-07-0045D	F	Case Head	4	11/16/-70	B	SSI	
B159	Wilburn, Rhonda F.	854-06-0398	F	Case Head	1	02/27/-25	A	AFDC-MN	
B160	Wilburn, Gail F.	625-08-6075	F	Dep Child	1	11/21/-04	A	AFDC-MN	
B161	Wright, Pamela N.	821-10-4391	F	Case Head	1	06/15/-29	A	AFDC-CN	Cancel effective +30
B162	Wright, Bricey A.	617-01-3757	M	Dep Child	1	09/21/-07	A	AFDC-CN	
B163	Wright, Roslyn	619-03-2261	F	Dep Child	1	10/02/-02	A	AFDC-CN	
B164	Yarborough, William S.	961-09-7081A	M	Case Head	2	12/02/-74	A	SSI	
B165	Young, Valarie	840-05-3337	F	Case Head	1	12/17/-22	C	AFDC-CN	
B166	Young, Debra	620-07-8428	F	Dep Child	1	07/24/-02	A	AFDC-CN	
B167	Zimmer, Agnes L.	873-09-7475	F	Case Head	1	07/02/-30	A	SSI	

RECIPIENT PROFILES
STATE ONLY

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
S1	Anchor, Bill R.	822-11-5123	M		1	05/10/-60	B		
S2	Bullock, Larry A.	801-65-9801	M	Case Head	1	10/20/-50	A		
S3	Bunson, Joyce B.	601-53-2403	F	Case Head	1	12/10/-64	B		
S4	Bunter, Alice Qu.	815-06-2403	F		1	05/11/-36	B		
S5	Coles, Donald A.	800-02-2301	M	Case Head	1	02/10/-49	F		
S6	Dilly, Bonnie V.	633-22-0567	F	Case Head	1	12/11/-59	B		
S7	Ducker, Peter P.	605-99-2309	M		2	01/10/-75	F		
S8	Duran, Ginna A.	621-03-1798	F	Dep Child	1	08/14/-10	A		
S9	Hoople, Sarah A.	912-15-2398	F		1	02/12/-15	B		
S10	Horner, Joseph A.	803-97-6201	M		1	10/12/-39	B		
S11	Loose, Mary M.	805-99-9876	F		1	10/26/-45	A		
S12	Moon, Georgia A.	633-81-4449	F		2	11/30/-73	B		
S13	Napoleon, Moses	864-23-5921	M	Case Head	1	10/12/-55	F		
S14	Oola, Dee R.	633-52-1123	F		2	11/12/-72	B		
S15	Post, Arthur L.	822-13-7705	M		1	01/13/-42	F		
S16	Pritchard, Joyce	621-09-8342	F	Dep Child	1	05/02/-14	A		
S17	Quinhagak, Martin	822-09-5603	M	Case Head	1	10/12/-48	F		
S18	Raider, John X.	811-63-2204	M		1	11/20/-39	B		
S19	Silvernail, Gary	822-56-9802	M		1	12/31/-48	B		

RECIPIENT PROFILES
STATE ONLY

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
S20	Supey, Salley L.	823-55-2222	F	Case Head	1	07/12/30	B		
S21	Wakaa, Mary	653-11-7304	F	Case Head	2	11/30/-67	F		
S22	Wild, John R.	844-65-2222	M	Case Head	1	05/07/-42	F		
S23	Wipple, Dennis A.	602-63-2204	M		2	05/10/-70	C		
S24	Zot, Harry P.	999-01-9923	M	Case Head	1	12/08/-49	A		

RECIPIENT PROFILES
NURSING HOME RESIDENTS

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
N1	Barrow, Emily K.	833-47-6644	F	Case Head	2	08/15/-75	A	SSI	
N2	Heathcote, Esther	954-82-1153	F	Case Head	2	04/25/-68	A	SSI	
N3	Okamoto, June S.	991-10-3523	F	Case Head	2	10/31/-83	A	SSI	
N4	Olmstead, Molly J.	853-20-4413	F	Case Head	2	05/16/-90	A	SSI	
N5	Overton, Celia P.	835-41-5753	F	Case Head	2	08/26/-67	A	SSI	
N6	Owens, Christine A.	971-37-0891	F	Case Head	2	11/11/-86	A	SSI	
N7	Patch, Charles L.	848-80-4712	M	Case Head	2	05/17/-81	A	SSI	
N8	Paton, Richard A.	875-21-6434	M	Case Head	2	03/28/-74	A	SSI	
N9	Pease, Louise L.	831-75-2378	F	Case Head	2	06/12/-85	A	SSI	
N10	Peterson, Frank	928-04-7523	M	Case Head	2	04/16/-74	A	SSI	
N11	Philips, Rex T.	807-46-6276	M	Case Head	2	04/15/-75	A	SSI	
N12	Pierce, Grant J.	857-48-2774	M	Case Head	2	01/02/-73	A	MR	
N13	Pool, Marsha A.	812-08-1177	F	Case Head	2	08/10/-88	A	MR	
N14	Price, Paula Z.	975-05-1035	F	Case Head	2	09/30/-82	A	MR	
N15	Renwick, Daniel M.	846-25-5702	M	Case Head	2	08/27/-72	A	MR	
N16	Robertson, Doug T.	857-02-9071	M	Case Head	2	07/31/-66	A	MR	
N17	Russell, Peter C.	931-45-6378	M	Case Head	2	07/08/-69	A	MR	
N18	Schiller, Paul M.	828-03-5317	M	Case Head	2	05/07/-77	A	SSI	
N19	Spellman, Gertrude A.	881-53-5461	F	Case Head	2	08/28/-70	A	SSI	
N20	Traynor, Kim B.	859-75-1952	F	Case Head	2	02/02/-75	A	SSI	

RECIPIENT PROFILES
HMO MEMBERS

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
H1	Adler, James C.	875-03-4251	M	Case Head	1	06/30/-35	E	AFDC-CN	
H2	Allsop, Mary M.	832-07-4882	F	Case Head	1	08/28/-27	E	AFDC-CN	
H3	Beermann, Douglas	901-04-8321	M	Case Head	2	12/05/-69	E	SSI	
H4	Belden, Marvin N.	827-04-3753	M	Case Head	1	04/14/-44	E	AFDC-MN	
H5	Bligh, Alfred O.	947-80-9645	M	Case Head	2	11/03/-75	E	SSI	
H6	DeBartolo, Anthony M.	825-007-4352	M	Case Head	1	02/24/-54	E	AFDC-CN	
H7	Ellison, Martha A.	861-52-7167	F	Case Head	1	09/20/-39	E	AFDC-CN	
H8	Elmore, Kim B.	931-41-7832	F	Case Head	2	10/13/-80	E	SSI	
H9	Farley, Louise L.	817-90-4624	F	Case Head	1	07/25/-47	E	AFDC-CN	
H10	Freund, Virginia P.	864-51-3457	F	Case Head	1	03/30/-62	E	AFDC-CN	
H11	Gibb, Alex B.	870-43-8225	M	Case Head	1	04/17/-36	E	AFDC-CN	
H12	Lesaro, Kathleen A.	812-53-7431	F	Case Head	1	01/17/-61	E	AFDC-CN	
H13	Myles, Karen F.	924-75-8961	F	Case Head	2	06/21/-77	E	SSI	
H14	Okeda, Patricia S.	807-23-4541	F	Inpatient	1	04/10/-49	E	AFDC-CN	
H15	Slotnick, Duane C.	896-71-6848	M	Inpatient	1	09/23/-52	E	AFDC-CN	

RECIPIENT PROFILES
SPECIAL PROGRAMS

Seq. No.	Name	SSN	Sex	Relation	Med. Cov.	Date of Birth	TPR	Program	Comments
M1	Herman, Allen L.	853-20-7651	M	Case Head	1	07/31/-58	A		
M2	Holzinger, Jack P.	871—53-6589	M	Case Head	1	04/17/-37	A		
M3	Marko, David P.	862-07-4125	M	Case Head	1	10/29/-49	A		
M4	McKinney, Stewart R.	874-30-0991	M	Case Head	1	01/27/-33	A		
M5	Merlin, Arthur K.	874-50-1063	M	Case Head	1	09/14/-41	A		
M6	Nagy, Paul O.	866-08-7488	M	Case Head	1	07/08/-27	A		
M7	Norkey, Greg M.	883-43-6941	M	Case Head	1	12/02/-33	A		
M8	Norman, Craig T.	805-45-1273	M	Case Head	1	05/11/-52	A		
M9	Norman, Harriet S.	802-85-6873	F	Case Head	1	05/27/-43	A		
M10	Olney, Jenny R.	814-50-9722	F	Case Head	1	04/23/-40	A		

CHAPTER V
TEST PROVIDERS

A profile page is presented for each of the 50 test providers. The codes used in the profiles are defined in the Provider Codes section. The codes are:

- Provider type
- Provider specialty
- Category of service

PROVIDER PROFILE

Sequence No.: 1

Provider Name	Medical Center Hospital	Title	
Social Security No.		Enrollment Date	-60
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	50-Hospital		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
650	Acute Care	16	Inpatient
		17	Outpatient
		18	Emergency
		19	Mental Health

Rate Data:

Code	Rate	Effective Date
Rate 1		-60

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 2

Provider Name	Good Samaritan Hosp. & Medical Ctr.	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	50-Hospital		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
650	Acute Care	16	Inpatient
		17	Outpatient
		18	Emergency
		19	Mental Health

Rate Data:

Code	Rate	Effective Date
Rate		0

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 3

Provider Name	Camelot Care Center	Title	
Social Security No.		Enrollment Date	-60
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	54-Nursing Home		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
100	SNF	21	Long-Term Care
103	ICF		

Rate Data:

Code	Rate	Effective Date
Rate 1		-60
Rate 2		+20

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 4

Provider Name	Park View Nursing Home	Title	
Social Security No.		Enrollment Date	+15
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	54-Nursing Home		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
103	ICF	21	Long-Term Care

Rate Data:

Code	Rate	Effective Date
Rate 1		+15
Rate	$0	+60

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

Note: Decertify effective +60

PROVIDER PROFILE

Sequence No.: 5

Provider Name	Midway Community Center		Title		
Social Security No.			Enrollment Date	0	
Employer Identification No.			Board Certification Date		
License Number			Board Certification Code		
Provider Type	55-ICF/MR				
Specialty	Code	Description	Category of Service	Code	Description
	105	ICF/MR		21	Long-Term Care

Rate Data:

	Code	Rate	Effective Date
Rate 1			0

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 6

Provider Name: Physicians Medical Laboratories Title: _____

Social Security No.: _____ Enrollment Date: -130

Employer Identification No.: _____ Board Certification Date: _____

License Number: _____ Board Certification Code: _____

Provider Type: 59-Independent Lab

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
090	All Testing	13	Lab Services
		15	Radiology

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: _____ Individual/ Group Number: _____

Address: _____

County: _____ Telephone No.: _____

PROVIDER PROFILE

Sequence No.: 7

Provider Name	Medical Diagnostic Laboratory	Title	
Social Security No.		Enrollment Date	-40
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	59-Independent Lab		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
090	All Testing	13	Lab Services
		15	Radiology

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 8

Provider Name	Edmiston, Richard E.	Title	DDS
Social Security No.	699-01-8328	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	41-Dentist		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
620	General	06	Dental

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	10-Family Dental
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 9

Provider Name	Schommer, Patrick T.	Title	DDS
Social Security No.	699-02-8732	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	41-Dentist		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
620	General	06	Dental

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	10-Family Dental
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 10

Provider Name	Family Dental Clinic	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	56-Dental Clinic		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
620	General	06	Dental
621	Oral Surgery		

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	8,9
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 11

Provider Name	Columbia Medical Clinic	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	53-Group Practice		

Specialty	Code	Description	Category of Service	Code	Description
	136	Family Medicine		10	Physician
	141	Internal Medicine			

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	27,28
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 12

Provider Name	Metropolitan Clinic	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	53-Group Practice		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
136	Family	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	29,30
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 13

Provider Name	Dickson Drug	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	57-Pharmacy		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
800	Pharmacy	08	Pharmacy

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 14

Provider Name	Hillsdale Pharmacy	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	57-Pharmacy		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
800	Pharmacy	08	Pharmacy

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 15

Provider Name: People's Health Clinic Title: _____

Social Security No.: _____ Enrollment Date: 0

Employer Identification No.: _____ Board Certification Date: _____

License Number: _____ Board Certification Code: _____

Provider Type: 63-Rural Health Clinic

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
136	Family/General	22	Rural Health

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: _____ Individual/Group Number: _____

Address: _____

County: _____ Telephone No.: _____

Note: Cancel effective +90

PROVIDER PROFILE

Sequence No.: 16

Provider Name: Associated Home Health Svcs., Inc. Title: _____

Social Security No.: _____ Enrollment Date: 0

Employer Identification No.: _____ Board Certification Date: _____

License Number: _____ Board Certification Code: _____

Provider Type: 62-Home Health Agency

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
		30	Home Health

Rate Data:

Code	Rate	Effective Date
Rate 1		0

Assigned Provider No.: _____ Individual/ Group Number: _____

Address: _____

County: _____ Telephone No.: _____

PROVIDER PROFILE

Sequence No.: 17

Provider Name	Chenoweth, Richard G.	Title	MD
Social Security No.	699-03-4530	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
148	Opthalmology	10	Physician
		05	Vision

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 18

Provider Name	Siddens, William B.	Title	OD
Social Security No.	699-04-2287	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	46-Optometrist		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
502	Optometrist	05	Vision

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 19

Provider Name: Audiology Associates Title: _____

Social Security No.: _____ Enrollment Date: . 0

Employer Identification No.: _____ Board Certification Date: _____

License Number: _____ Board Certification Code: _____

Provider Type: 48-Audiologist

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
		25	Hearing Svcs.

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: _____ Individual/ Group Number: _____

Address: _____

County: _____ Telephone No.: _____

PROVIDER PROFILE

Sequence No.: 20

Provider Name: Beddoe, Gladys M. Title: MD

Social Security No.: 699-05-0543 Enrollment Date: 0

Employer Identification No.: Board Certification Date:

License Number: Board Certification Code:

Provider Type:

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
149	Otorhinolarangology	10	Physician
		25	Hearing

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: Individual/ Group Number:

Address:

County: Telephone No.:

PROVIDER PROFILE

Sequence No.: 21

Provider Name	Parker, Kathy	Title	DPM
Social Security No.	699-06-7478	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	49-Podiatrist		

Specialty	Code	Description	Category of Service	Code	Description
	185	Podiatrist		32	Podiatry

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 22

Provider Name	Care Ambulance Services	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	60-Transportation		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
400	Ambulance	04	Transportation

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 23

Provider Name: Metro-West Ambulance Service Title: _____

Social Security No.: _____ Enrollment Date: Not Enrolled

Employer Identification No.: _____ Board Certification Date: _____

License Number: _____ Board Certification Code: _____

Provider Type: 60-Transportation

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
400	Ambulance	04	Transportation

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: _____ Individual/ Group Number: _____

Address: _____

County: _____ Telephone No.: _____

PROVIDER PROFILE

Sequence No.: 24

Provider Name	Radio Cab Company	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	60-Transportation		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
402	Taxi	04	Transportation

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 25

Provider Name	Stanke, Roger W.	Title	MD
Social Security No.	699-07-8820	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
151	Pediatrics	10	Physician
		23	EPSDT

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 26

Provider Name	Cristofani, Daniel L.	Title	MD
Social Security No.	699-08-2331	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
139	Gynocology	10	Physician
		12	Family Planning

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 27

Provider Name	Fraback, Ronald C.	Title	MD
Social Security No.	699-09-8857	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
141	Internal Medicine	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	11-Columbia Medical
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 28

Provider Name	McGreevey, Donald P.	Title	MD
Social Security No.	699-10-3171	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
141	Internal Medicine	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	11-Columbia Medical
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 29

Provider Name	Grimwood, David C.	Title	MD
Social Security No.	699-11-2929	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
136	Family/General	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	12-Metropolitan
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 30

Provider Name	Harpole, Bernard P.	Title	MD
Social Security No.	699-12-3450	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
136	Family/General	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	12-Metropolitan
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 31

Provider Name	Krygier, John J.	Title	MD
Social Security No.	699-13-4967	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
153	Psychiatry	10	Physician
154	Psychiatry, Child	19	Mental Health

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 32

Provider Name: Battalia, Jack E. Title: MD

Social Security No.: 699-14-4323 Enrollment Date:

Employer Identification No.: Board Certification Date:

License Number: Board Certification Code:

Provider Type: 40-Physician

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
160	Surgery, General	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: Individual/ Group Number:

Address:

County: Telephone No.:

PROVIDER PROFILE

Sequence No.: 33

Provider Name	Snedecor, Phillip A.	Title	MD
Social Security No.	699-15-0452	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
160	Surgery, General	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 34

Provider Name	Lindell, Thomas D.	Title	MD
Social Security No.	699-16-1582	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
	Diagnostics	10	Physician
160	Surgery, General	18	Emergency

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	Employed by 2-Good Samaritan
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 35

Provider Name	Giles, Kenneth M.	Title	MD
Social Security No.	699-17-0418	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
136	Family/General	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

Note: All claims subject to manual review

PROVIDER PROFILE

Sequence No.: 36

Provider Name	Smith, John M.	Title	MD
Social Security No.	699-28-1298	Enrollment Date	Not Enrolled
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
136	Family/General	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 37

Provider Name	Jones, James R.	Title	MD
Social Security No.	699-29-7359	Enrollment Date	Not Enrolled-Ineligible
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	40-Physician		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
136	Family/General	10	Physician

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 38

Provider Name: Pedes, Kenneth G. Title:

Social Security No.: 699-38-5371 Enrollment Date: 0

Employer Identification No.: Board Certification Date:

License Number: Board Certification Code:

Provider Type: 47-Optician

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
501	Optician	05	Vision
		14	MS/DG

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: Individual/ Group Number:

Address:

County: Telephone No.:

PROVIDER PROFILE

Sequence No.: 39

Provider Name: Sherwood, June L. Title:

Social Security No.: 699-39-0897 Enrollment Date: 0

Employer Identification No.: Board Certification Date:

License Number: Board Certification Code:

Provider Type: 44-Therapist

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
180	Physical Therapy	31	Other Practitioner

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.: Individual/ Group Number:

Address:

County: Telephone No.:

PROVIDER PROFILE

Sequence No.: 40

Provider Name	Allied Medical Equipment		Title		
Social Security No.			Enrollment Date		
Employer Identification No.			Board Certification Date		
License Number			Board Certification Code		
Provider Type	58-DME Supplier				
Specialty	Code	Description	Category of Service	Code	Description
	451	DME		14	MS/DG

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 41

Provider Name	Cooperative Health Care	Title	
Social Security No.		Enrollment Date	-30
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	51-HMO		

Specialty	Code	Description	Category of Service	Code	Description

Rate Data:

	Code	Rate	Effective Date
Rate 1			-30
Rate 2			0
Rate 3			+30

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 42

Provider Name	Jorgenson, Sarah L.	Title	RN
Social Security No.	699-42-7320	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	42-Nurse		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
208	Nurse-Midwife	31	Other Practitioner

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 43

Provider Name	Schultz, Margaret T.	Title	RN
Social Security No.		Enrollment Date	
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	42-Nurse		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
209	RN	31	Other
		30	Home Health

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	16-Assoc. Home Health
Address			
County		Telephone No.	

Note: Private Duty Nurse

PROVIDER PROFILE

Sequence No.: 44

Provider Name	Bingham, Jack C.	Title	DC
Social Security No.	699-44-4473	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	43-Chiropractor		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
		26	Chiropractic

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 45

Provider Name	Jacoby, George E.	Title	
Social Security No.	699-45-9132	Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	44-Therapist		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
182	Speech	31	Other

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 46

Provider Name	Ditullio, Herve		Title	
Social Security No.	699-46-4895		Enrollment Date	0
Employer Identification No.			Board Certification Date	
License Number			Board Certification Code	
Provider Type	44-Therapist			

Specialty	Code	Description	Category of Service	Code	Description
	181	Occupational		31	Other

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 47

Provider Name	Quik-Care Centers, Inc.	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	52-Ambulatory Surgery		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 48

Provider Name	Central Mental Health Services	Title	
Social Security No.		Enrollment Date	0
Employer Identification No.		Board Certification Date	
License Number		Board Certification Code	
Provider Type	CMHC		

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
		19	Mental Health

Rate Data:

Code	Rate	Effective Date

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

PROVIDER PROFILE

Sequence No.: 49

Provider Name: Southwest Rural Hospital Title:

Social Security No.: Enrollment Date: 0

Employer Identification No.: Board Certification Date:

License Number: Board Certification Code:

Provider Type: 50-Hospital

Specialty Code	Specialty Description	Category of Service Code	Category of Service Description
650	Acute Care	16	Inpatient
	Chronic Care	17	Outpatient
	Psychiatric	19	Mental Health
	Swing Beds		

Rate Data:

Code	Rate	Effective Date
Rate 1		0

Assigned Provider No.: Individual/ Group Number:

Address:

County: Telephone No.:

PROVIDER PROFILE

Sequence No.: 50

Provider Name	Elwood Care Unit		Title		
Social Security No.			Enrollment Date		
Employer Identification No.			Board Certification Date		
License Number			Board Certification Code		
Provider Type	54-Nursing Home				
Specialty	Code	Description	Category of Service	Code	Description
	104	Pediatric SNF		21	Long-Term Care

Rate Data:

Code	Rate	Effective Date
Rate 1		0

Assigned Provider No.		Individual/ Group Number	
Address			
County		Telephone No.	

CATEGORIES OF SERVICE

Code	Description
02	Non-Institutional
04	Transporattion
05	Vision Care
06	Dental
08	Pharmacy
10	Physician Services
12	Family Planning
13	Laboratory
14	Medical Supplies and Durable Goods
15	Radiology
16	Inpatient
17	Outpatient
18	Emergency Services
19	Mental Health
20	Tuberculosis
21	Long-Term Care
22	Rural Health Services
23	EPSDT
25	Hearing Services
26	Chiropractic Services
27	Ambulatory Surgery
28	Mental Health
29	Speech Disorder Services
30	Home Health Services
31	Other Practitioner
32	Podiatry

PROVIDER CODE

Provider Type		Specialties		Allowable Categories of Service
Code	Name	Code	Name	
40	Physician	130	Allergy/Immunology	05, 10, 12, 23, 25
		131	Anesthesiology	
		132	Cardiovascular Medicine	
		133	Dermatology	
		134	Emergency Medicine	
		135	Endocrinology	
		136	Family/General Practice	
		137	Gastroenterology	
		138	Geriatrics	
		139	Gynecology	
		140	Hematology	
		141	Internal Medicine	
		142	Neonatology	
		143	Nephrology	
		144	Neurology	
		145	Nuclear Medicine	
		146	Obstetrics	
		147	Oncology	
		148	Ophthalmology	
		149	Otorhinolaryngology/ Laryngology/ Pharyngology	
		150	Pathology	
		151	Pediatrics	
		152	Physical Medicine and Rehabilitation	
		153	Psychiatry	
		154	Psychiatry, Child	
		155	Pulmonary Medicine	
		156	Radiology, Diagnostic	
		157	Radiology, Therapeutic	
		158	Surgery, Cardiothoracic	
		159	Surgery, Colon and Rectal	
		160	Surgery, General	
		161	Surgery, Neurological	
		162	Surgery, Orthopedic	
		163	Surgery, Pediatrics	
		164	Surgery, Plastic and Reconstructive	

PROVIDER CODE (continued)

Provider Type		Specialties		Allowable Categories of Service
Code	Name	Code	Name	
		165	Surgery, Vascular	
		166	Surgery, Other	
		167	Urology	
41	Dentist	620	General Dentistry	06
		621	Oral Surgery	
		622	Endodontics	
		623	Pedodontics	
		624	Periodontics	
		625	Prosthodontics	
		626	Geriatric Dentistry	
		627	Handicapped Dentistry	
42	Nurse	206	Nurse Practitioner	02
		207	Nurse Anesthetist	
		208	Nurse Midwife	
		209	Registered Nurse	
43	Chiropractor		None	26
44	Therapist	180	Physical Therapy	31
		181	Occupational Therapy	
		182	Speech Therapy	
		183	Rehabilitation Therapy	
45	Psychiatrist	701	Psychiatric Day Treatment	28
46	Optometrist	502	Optometrist	05
47	Optician	501	Optician	05
48	Audiologist		--	25
49	Podiatrist	185	Podiatrist	32
50	Hospital	650	Acute Care	16, 17, 18, 19, 20, 21

PROVIDER CODE (continued)

Provider Type		Specialties		Allowable Categories of Service
Code	Name	Code	Name	
51	HMO	650	Acute Care	16, 17, 18
52	Ambulatory Surgical Care	195	Clinic	27
53	Group Practice Organization		—	22
54	Skilled Nursing Facility	100	SNF	21
		103	ICF	
		104	Pediatric SNF	
55	Intermediate Care Facility	105	ICF-Mentally Retarded	21
56	Dental Clinic		—	06
57	Pharmacy	800	Pharmacy	08, 14
		451	Medical Supplies and Durable Goods	
		452	Prosthetics	
58	Medical Supplies and Durable Goods Store	451	Medical Supplies and Durable Goods	14
		452	Prosthetics	
59	Certified, Independent Labs	030	Chemistry	13, 15
		070	X-Rays	
		090	Certified for All Testing	
60	Transportation	400	Ambulance	04
		402	Taxi	
61	Home Health Agency		--	30

CHAPTER VI
REFERENCE SCHEDULES

The following reference schedules are provided for the convenience of the test coordinator:

- HCPCS Procedure Codes
- ICD-9-CM Procedure Codes
- ICD-9-CM Diagnosis Codes
- NDC Drug Codes

HCPCs CODES FOR BPST CLAIMS

HCPCs Code	Description	State Code
A0010-A0999	Transportation	
A0010	Ambulance service, base rate emergency loaded, one way	
A0020	Ambulance service, per mile, loaded, one way	
A0060	Ambulance service, waiting time, one-half hour increments	
A0100	Non-emergency transportation: taxi-intra city	
A0180	Non-emergency transportation: ancillary: lodging-recipient	
A0190	Non-emergency transportation: ancillary: meals-recipient	
A2000-A2999	Chiropractic Manipulation	
A4000-A499	Medical Supplies	
E0000-E9999	Durable Medical Equipment	
H0000-H4999	Home Health Services	
H5000-H9999	Rehabilitative Services	
J0000-J8999	Drugs Administered - Other Than Oral Medication	
L0000-L9999	Orthotic Procedures and Devices	

HCPCs Code	Description	State Code
M0000-M9999	HCFA Assignment of Medical Services	
P0000-P9999	HCFA Assignment of Pathology and Laboratory Tests	
R0000-R5999	Diagnostic Radiology Services	
R6000-R6999	Diagnostic Ultrasound Services	
R7000-R7999	Diagnostic Radiotherapy Services	
R8000-R8999	Diagnostic Nuclear Medicine Services	
T0000-T9999	Surgical Services	
V0000-V0999	Vision Services	
V0100	Eye exam, including history, visual acuity test, eye biocular measure, opthalmoscopy, and tonometry	
V0280	Bifocal lens service (dispensing fee)	
V0490	Single vision lens service (dispensing fee)	
V2020	Frames, purchases	
V2035	Frames (dispensing fee)	
V2100	Sphere, single vision, plano to plus or minus 4.00, per lens	
V2200	Sphere, bifocal, plano to plus or minus 4.00, per lens	
V5000	Complete audiometric exam	

HCPCs Code	Description	State Code
V5010	Complete learning aid evaluation test	
V5050	Hearing aid, monaural, in the ear	
V5090	Dispensing fee	
00000-09999	Dental	
00110	Initial oral exam	
00120	Periodic oral exam	
00210	Radiographs, intraoral, complete series	
00220	Radiographs, periapical, single, first film	
01110	Dental prophylaxis, adults	
01120	Dental prophylaxis, children	
01220	Topical application of stannous floride, one treatment	
01330	Oral hygiene instruction	
02140	Amalgam, one surface, permanent	
05110	Complete upper dentures	
07110	Extraction, single tooth	
07240	Surgical extraction, including impacted tooth	
10000-99999	Current Procedural Terminology (CPT)	
10060	Incision and drainage of abscess, simple	
10061	Incision and drainage of abscess, complicated	
10080	Drainage of pilonidal cyst, simple	

HCPCs Code	Description	State Code
11100	Biopsy of skin, subcutaneous tissue or mucous membrane	
11601	Excision of malignant lesion, 0.5 to 1.0 cm	
12011	Repair of facial wound up to 2.5 cm	
15780	Abrasion of facial skin for removal of scars/tattoos	
19120	Excision of cyst on breast, unilateral	
19180	Mastectomy, simple, complete, unilateral	
19181-50	Mastectomy, simple, complete bilateral	
19325	Mammoplasty, augmentation, bilateral	
24900	Amputation, arm	
26010	Drainage of finger tip abscess, simple	
26011	Drainage of finger tip abscess, complicated	
26035	Decompression fingers/hand, injection injury	
26320	Removal of implant, hand/finger	
26350	Flexor tendon repair, single	
26750	Distal phalangeal fracture without manipulation	
26951	Amputation, finger or thumb	
27301	Incision and drainage of abscess, femur, or knee	
27331	Arthrotomy, knee with joint exploration	
27332	Arthrotomy, knee, for excision of semilunar cartilage	

HCPCs Code	Description	State Code
28190	Removal of foreign body, foot, subcutaneous	
28400	Calcaneal fracture, closed, without manipulation	
28800	Amputation, foot, midtarsal	
29130	Application of finger splint	
33910	Pulmonary embolectomy	
40812	Excision of lesion with simple repair, Vestibule of mouth	
41870	Periodontal mucosal grafting	
42825	Tonsilectomy, under age 12	
42830	Adenoidectomy, under age 12	
44600	Suture of intestine	
44950	Appendectomy	
44955	Appendectomy at time of other major procedure	
46230	Excision of external hemorrhoids	
49420	Insertion of intraperitoneal catheter for drainage	
49581	Repair of umbilical hernia, over age 5	
52275	Cystourethroscopy, with interal urethrotomy, male	
5380	Drainage of perineal urinary extravasation	
55980	Intersex surgery, female to male	
58150	Total hysterectomy	

HCPCs Code	Description	State Code
58600	Transection of fallopian tube	
58605	Transection of fallopian tube, postpartum, same hospitalization	
58720	Salpingo-oophorectomy	
59050	Internal fetal monitoring during labor	
59400	Total obstetrical care	
59420	Antepartum care only	
59521	Cesarean section, including total obstetrical care	
64831	Repair of nerve, suture, digital, one nerve	
64834	Repair of nerve, suture, hand/foot, one nerve	
55920	Extraction of lens (cataract)	
67938	Removal of embedded foreign body from eyelid	
69000	Drainage of abscess, external ear	
69210	Removal of impacted cerumen (ear)	
71010	Radiologic exam, chest, single view	
21020	Radiologic exam, chest, two views	
73615	Radiologic exam, ankle, supervision, and interpretation only	
74000	Radiologic exam, abdomen, single view	
80003	Automated multichannel tests/3 clinical chemistry tests	
80004	Automated multichannel test; 4 clinical chemistry tests	

HCPCs Code	Description	State Code
80005	Automated multichannel test; 5 clinical chemistry tests	
81000	Urinalysis, routine, with microscopy	
81005	Urinalysis, chemical, qualitative	
81099	Unlisted urinalysis procedure	
82100	Alkaloids, urine; screening	
82245	Bile pigments urine	
85022	Blood Count, hemogram, automated	
85031	Blood count, hemogram, manual complete CBC	
88150	Cytopathology smears (e.g., Papanicolaou)	
90010	Office visit, limited, new patient	
90015	Office visit, intermediate, new patient	
90017	Office visit, extended, new patient	
90020	Office visit, comprehensive, new patient	
90040	Office visit, brief, established patient	
90050	Office visit, limited, established patient	
90060	Office visit, intermediate, established patient	
90100	Home visit, brief, new patient	
90150	Home visit, limited, established patient	
90200	Hospital visit, brief, initial care	
90215	Hospital visit, intermediate, initial care	
90240	Hospital visit, brief, subsequent care	

HCPCs Code	Description	State Code
90260	Hospital visit, intermediate, subsequent care	
90515	Emergency room, intermediate, new patient	
90600	Consultation, limited	
90605	Consultation, intermediate	
90620	Consultation, comprehensive	
90699	Unlisted service, general	
90707	Measles, mumps, rubella vaccine	
90843	Individual psychotherapy, 20-30 minutes	
90844	Individual psychotherapy, 45-50 minutes	
90966	Peritoneal dialysis, patient over 40 kg.	
92002	Opthalmological exam, intermediate, new patient	
92012	Opthalmological exam, intermediate, established patient	
92392	Supply of low vision aids	
92551	Audiometry, basic, screening	
92557	Audiometry, basic, comprehensive	
92575	Audiometry, speech, sensorineural acuity	
93040	Rhythm ECG, with interpretation	
93791	Electronics analysis of internal pacemaker	
95005	Allergy test, scratch or puncture	
97799	Unlisted physical medicine procedure	

HCPCs Code	Description	State Code
CPT-4 Modifiers		
-22	Unusual Services (Medicine)	
-50	Multiple or Bilateral Procedures (Surgery)	
-80	Assistant Surgeon (Surgery)	

ICD-9-CM PROCEDURE CODES

This table provides a listing of all ICD-9-CM procedure codes used for BPST Inpatient Hospital claims. ICD-9-CM procedure codes are frequently used by hospitals for inpatient claims. The corresponding CPT-4 code is also provided. For items with an asterisk (*) in the CPT-4 code column, no corresponding CPT-4 code exists.

The purpose of this list is to facilitate the Test Coordinator's effort to convert the coding scheme used in the test to the State coding scheme. Note that space is provided to annotate the corresponding State code.

ICD-9-CM PROCEDURE CODES FOR INPATIENT HOSPITAL CLAIMS

ICD-9-CM Code	Description	CPT-4 Code
28.2	Tonsilectomy without adenoidectomy	42825 42826
28.3	Tonsilectomy with adenoidectomy	42820 42821
39.98	Control of hemorrhage	*
40.23	Excision of axillary lymph node	38500
45.31	Local excision of lesion of duodenum	44110
47.0	Appendectomy	44950
60.11	Needle biopsy of prostate	55700
66.39	Transection of fallopian tube	58600
68.4	Total abdominal hysterectomy	58150
69.98	Other operations on supporting structures of uterus	*
72.9	Unspecified instrumental delivery (obstetric)	59410
73.59	Other manually assisted delivery	59410
74.0	Classical Cesarean section	59520
83.42	Other tenonectomy	*
85.53	Unilateral breast implant	19310
87.17	Other X-ray of skull	70250
94.38	Supportive verbal psychotherapy	90841
94.39	Other individual psychotherapy	90841
99.02	Autotransfusion of whole blood	86128

ICD-9-CM DIAGNOSIS CODES

This table provides a listing of all ICD-9-CM diagnosis codes used in BPST. A conversion table is not provided because this diagnosis coding scheme is mandated for Medicaid systems.

The purpose of this table is to provide a comprehensive list of codes used to facilitate additions or deletions in test claims by the Test Coordinator.

ICD-9-CM CODES FOR ALL CLAIMS

ICD-9-CM Code	Description
0008.8	Intestinal infection due to other organism
009.2	Infectious diarrhea
011.2	Tuberculosis of lung with cavitation
034.1	Scarlet fever
055.71	Measles kerato conjunctivitis
056.9	Rubella without complication
070.1	Viral hepatitis A without hepatic coma
072.9	Mumps without complication
082.8	Other specified tick-borne rickettsioses
123.4	Diphyllobothriasis, intestinal
173.6	Other malignant neoplasm of skin of upper limb
174.9	Malignant neoplasm of female breast, unspecified
179.0	Malignant neoplasm of uterus, part unspecified
229.0	Benign neoplasm of lymph nodes
238.3	Neoplasm of uncertain behavior of breast
290.3	Senile dementia with delirium
291.0	Alcohol withdrawal delirium
293.1	Transient organic psychotic condition, subacute delirium
295.3	Schizophrenic disorder, paranoid type
366.45	Toxic cataract
366.9	Unspecified cataract
369.16	Psychophysical visual disturbances
369.70	Moderate to severe vision impairment, one eye, other eye not specified

ICD-9-CM CODES FOR ALL CLAIMS

ICD-9-CM Code	Description
379.90	Unspecified disorder of eye
380.10	Infective otitis externa, unspecified
388.70	Otalgia, unspecified
389.10	Sensorineural hearing loss, unspecified
389.11	Sensory hearing loss
415.1	Pulmonary embolism and infarction
427.9	Cardiac dysrhythmia, unspecified
428.1	Left heart failure
428.9	Heart Failure, unspecified
429.0	Myocarditis, unspecified
429.2	Cardiovascular disease, unspecified
455.5	External hemorrhoids with other complication
459.0	Hemorrhage, unspecified
460	Acute nasopharyngitis
462	Acute pharyngitis
463	Acute Tonsillitis
474.10	Hypertrophy of tonsils and adenoids
480.9	Viral pneumonia, unspecified
486	Pneumonia, organism unspecified
487.1	Influenza with other respiratory manifestations
487.8	Influenza with other manifestations
490	Bronchitis
524.9	Unspecified dentofacial anomalies

ICD-9-CM CODES FOR ALL CLAIMS

ICD-9-CM Code	Description
525.8	Other disorders of teeth and supporting structures
525.9	Unspecified disorder of teeth and supporting structures
528.8	Oral submucosal fibrosis
531.9	Gastric ulcer without mention of hemorrhage or perforation
532.0	Acute duodenal ulcer with hemorrhage
532.5	Chronic Duodenal ulcer with perforation
540	Acute appendicitis
540.9	Acute appendicitis without mention of peritonitis
541	Appendicitis, unqualified
553.1	Umbilical hernia
562.11	Diverticulitis of colon
569.42	Anal or rectal pain
569.83	Perforation of intestine
599.1	Urethral fistula
599.6	Urinary obstruction, unspecified
599.7	Hematuria
601.1	Inflammatory disease of prostate
610.0	Solitary cyst of breast
615.1	Chronic inflammatory disease of uterus
617.2	Endometriosis of fallopian tube
621.5	Intrauterine synechiae
625.2	Mittelschmerz
627.0	Premenopausal menorrhagia

ICD-9-CM CODES FOR ALL CLAIMS

ICD-9-CM Code	Description
644.0	Threatened premature labor
644.1	Other threatened labor
644.21	Premature labor with onset of delivery
650	Normal delivery
652.3	Transverse or oblique presentation of fetus
669.7	Cesarean delivery
669.9	Unspecified complication of labor and delivery
680.0	Carbuncle or furuncle on face
680.1	Carbuncle or furuncle on neck
681.0	Cellulitis and abscess of finger
682.6	Cellulitis and abscess of leg
692.6	Contact dermatitis due to unspecified cause
724.2	Lumbago
727.02	Giant cell tumor of tendon sheath
734	Flat feet
783.2	Abnormal loss of weight
784.0	Headache
784.1	Throat pain
785.4	Gangrene
786.2	Cough
786.3	Hemoptysis
786.50	Chest pain, unspecified
786.52	Painful respiration

ICD-9-CM CODES FOR ALL CLAIMS

ICD-9-CM Code	Description
786.3	Hemoptysis
786.5	Chest pain, unspecified
786.52	Painful respiration
787.0	Nausea and vomiting
788.0	Renal colic
788.1	Dysuria
789.0	Abdominal pain
789.3	Abdominal or pelvic swelling, mass, or lump
824.3	Fracture of latheral malleolus, open
825.0	Fracture of calcaneus, closed
836.1	Tear of lateral cartilage or meniseus of knee
845.1	Sprain of foot
847.0	Sprain of neck
867.6	Injury of other specified pelvic organs
882.0	Open wound of hand without complication
882.2	Open wound of hand with tendon involvement
896.0	Traumatic amputation of foot, unilateral without complication
914.6	Superficial foreign body in hand without open wound or infection
916.7	Superficial foreign body in lower extremity, infected, without open wound
917.6	Superficial foreign body in foot or toe without open wound or infection
924.3	Contusion of toe

ICD-9-CM CODES FOR ALL CLAIMS

ICD-9-CM Code	Description
926.1	Crushing injury of trunk - other (breast)
927.09	Crushing injury of shoulder and upper arm, multiple sites
927.3	Crushing injury of fingers
930.1	Foreign body in conjunctival sac
944.11	First degree burn of single finger
949.0	Unspecified burn
959.2	Unspecified injury to shoulder and upper arm
959.5	Unspecified injury to finger
959.6	Unspecified injury to hip and thigh
959.7	Unspecified injury to lower extremity
965.02	Poisoning by methadone
992.0	Heatstroke or sunstroke
V06.1	Need for prophylactic vaccination, DTP
V22.1	Supervision of normal pregnancy, other than first
V22.2	Pregnant state, incidental
V24.0	Postpartum care, immediately after delivery
V25.09	Other contraceptive management
V25.2	Sterilization
V50.1	Plastic surgery for unacceptable cosmetic appearance
V50.9	Unspecified elective surgery, other than health reasons

NDC DRUG CODES

The drug codes used in BPST are provided in the following table. The following characteristics are identified for the drug codes:

- Over-the-counter (OTC) drug
- Federal Maximum Allowable (Fed MAC) cost price
- Available in unit dose form
- Generic equivalent NDC code
- Identification as "less than effective"
- Identified on the most prescribed listing

DRUG CODES (NDC)

NDC Code	Drug Name	OTC	Fed. MAC	Unit Dose	Generic	Less Than Effective	Most Prescribed
0002-1033-02	Phenobarbitol - 100 mg.						
0781-1110-13	Phenobarbitol - 250 mg.			X			
0002-1010-02	Codeine Sulfate - 30 mg.						
0003-0327-01	Codeine Sulfate - 60 mg.						
0002-8440-01	lletin (insulin) Lente - 40 u/cc						
0003-3527-15	lnsulin Lente - 40 u/cc						
0140-0005-01	Valium - 5 mg.						
0140-0006-14	Valium - 10 mg.						
0140-0003-01	Librium - 25 mg.						
0006-0047-68	Vivactil - 10 mg.						
0006-0047-28	Vivactil - 10 mg.			X			
0006-0097-50	Decadron - 4 mg.						
0015-7893-60	Dynapen - 250 mg.				0536-1180-01		
0026-3511-20	Domol Liquid Bath & Shower Oil	X					
0039-0060-10	Lasix - 40 mg.				0536-3841-01		
0045-5015-60	Tylenol w/codeine - 60 mg.		X		0536-3215-01		
0045-0496-60	Tylenol tablets	X			0536-3231-01		
0046-0424-81	lnderal - 40 mg.						
0046-0424081	Premarin - 2.5 mg.				0536-3528-01		
0048-1170-03	Synthroid 0.3 mg.				0536-3958-10		
0083-0007-30	Ritalin - 5 mg.				0182-1173-01		
0037-5101-01	Milpath - 200					X	
0037-1101-01	Miltown - 200 mg.		X		0228-2016-10		
0718-1205-01	Penicillin VK - 250 mg		X				
0068-1027-04	Novahistine DH						
0879-0093-01	Aspirin - 5 gr.	X					
0007-3326-25	Combid Spansule				0536-3957-05		
0081-0194-98	Cortisporin Cream					X	
0140-0007-01	Librax				0536-3490-01	X	X
0182-0977-01	Chlordiazepoxide HCL		X				
0045-0322-60	Parafon Forte				0781-1698-01	X	X
0087-0543-01	Vasodilan - 10 mg.				0781-1840-01	X	X
0087-0543-05	Vasodilan - 10 mg.			X	0781-1840-13	X	X

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